

**BETHLEHEM ENT ASSOCIATES**  
**PEDIATRIC HEALTH HISTORY QUESTIONNAIRE**

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

**CORRECT WAY TO MARK CIRCLES: ●**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Family doctor: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Who completed the health history questionnaire for the patient? Complete name. \_\_\_\_\_

What is your relationship to the patient?  Parent  Grandparent  Other relative  Guardian  
 Other, please explain:

How did you hear about our office?  Emergency Room  Friend  Phone Book  Newspaper  
 Relative  Doctor  Other:

1. What is the reason for today's visit?

2. What medications does the child take?

None  Aspirin  Ibuprofen (Advil, Motrin)  Tylenol

Additional medications list below, include over the counter medications.

<u>Name of Drug</u>	<u>Strength</u>	<u>Frequency Taken</u>

3. Does the child have any Allergies or Reactions?  No  Yes If yes, please list below:

<u>Allergy</u>	<u>Type of reaction</u>

4. Has the child had any surgeries?  No  Yes If yes, please list below:

<u>Year</u>	<u>Reason</u>	<u>Hospital</u>

5. Is the child a full time student?  No  Yes If yes, what grade level is the child.

6. Does the child attend daycare?  No  Yes

7. Who does the child live with?  Parents  Mother  Father  Grandparents  Guardian

Other, please explain:

