Child New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: Date of Birth:

Parent or Guardian's Name: / /

Chief Complaint or Concern:

MEDICATIONS (including prescription and over-the-counter)

1. 5.
2. 6.
3. 7.
4.

Does your child have any allergies to any medications? ◯ Yes ◯ No

If yes, please list:

PAST SURGICAL HISTORY

1. 5.
2. 6.
3. 7.
4. 8.

Has your child ever had your tonsils and/or adenoids surgically removed? ◯ Yes ◯ No

ALLERGY HISTORY

○ None Known ◉ Yes, to 1. 3.

2. 4.

Pets: ◉ **No** ○ **Yes How many?** **What type of pet?**

Do any pets sleep in your child's bedroom? ○ **No** ◉ **Yes**

Which pets?

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply}:

High blood pressure/hypertension	Diabetes	Chronic insomnia
Heart disease	Overweight/obesity	Restless legs syndrome
Stroke	Snoring	Multiple Sclerosis
Congestive heart failure	Sleep apnea	Sleep Walking
Depression	Anxiety	

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite:	○ Yes	○ No
Fever:	○ Yes	○ No
Fatigue:	○ Yes	○ No
Weight Gain:	○ Yes	○ No
Weight Loss:	○ Yes	○ No

Respiratory:

Cough:	○ Yes	○ No
Asthma:	○ Yes	○ No
Wheezing:	○ Yes	○ No
Poor Exercise Tolerance:	○ Yes	○ No

Children and Adolescents

Sleep, Breathing & Habit Questionnaire

Patient's Name: Age: Date:

Please indicate if your child experiences or has experienced any of the symptoms below by using this scale to measure the severity of these symptoms.

0 -No Occurrence 1 -Occurs Rarely 2 -Occurs 2 to 4 times per week 3 - Occurs 5 to 10 times per week

Snoring

Interrupted snoring where breathing stops

Labored, difficult or loud breathing at night

Gasping for air while sleeping

Mouth breathes while sleeping

Mouth breathes during the day

Restless sleep

Grinds teeth while sleeping

Talks in sleep

Excessive sweating while sleeping

Wakes up at night

Wets the bed (currently)

History of bedwetting

Feels sleepy and/or irritable during the day

Headaches

Frequent throat infections

Seasonal allergies

Ear infections or history of ear infections

Short attention span

Trouble Focusing

Difficulty listening/often interrupts

Hyperactive

ADD/ ADHD

Sensory issues

Struggles with math at school

Struggles with reading at school

Speech issues

Avoidance behavior towards food or certain

***Speech Questionnaire** -to be filled out only it #27 was indicated above
*Please check all **that** apply to your child*

It's difficult to understand your clild's speech?

Difficult to understand over the phone?

Nasal speech?

Hoarseness?

Others have difficulty understanding speech?

Gets frustrated when people can't understand speech?

Speech sounds abnormal?

Sometimes omits consonants?

Uses M, N, NG instead of P, V, S, Z sounds

Liquids and/or solids get into nasal area when eating or drinking?

Uses M, N, NG instead of P, V, S, Z sounds?

Liquids and/or solids get into nasal area when eating or drinking?