

PEDIATRIC NEW PATIENT HISTORY FORM

To our new patients: To help us establish each patient with our practice, please provide us your child's complete health history including all physical and mental symptoms.

PERSONAL HISTORY

Child's Name: _____ **Date -** _____
DOB: _____
Current Home (circle one): O'ahu 'Big Island' Maui Kaua'i Moloka'i Other: _____
Parent's Occupation: _____ Child's Birthplace: _____
Primary Care Doctor: _____ Referred by (if different): _____

Preferred Pharmacy for us to call in medications (if necessary): _____

REASON FOR YOUR VISIT: _____

ALLERGIES: (Medicines, Foods, Pollens, Pets etc.) **No Known Medication Allergies**

CURRENT MEDICATIONS & INHALERS: <input type="checkbox"/> I have a list with me	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
<input type="checkbox"/> Check here if you do not take any medications		

PERSONAL MEDICAL HISTORY

Check those that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bronchitis/Emphysema | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritable Bowels |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Eye Problems/Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> Easy Bleeding or Bruising |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Other: _____ | | |

PAST SURGICAL & TRAUMA HISTORY

List prior Surgeries, Injuries, & Hospitalizations

Date/Month and Year

LIFESTYLE / SELF-CARE ISSUES

- Does anyone smoke cigarettes in the household? YES NO If yes, how many? # _____ yrs. _____ packs per day
- Is your child in Daycare? YES NO If yes, starting at what age? _____
- Does your child have any siblings? YES NO If yes, how many? Brothers _____ & Sisters _____
- Any pets at home? YES NO If yes, which? _____
- In School? YES NO If yes, please list school/grade? _____

DO ANY OF THESE CONDITIONS RUN IN YOUR FAMILY?:

Bleeding Disorders? YES NO If yes, explain: _____
Problems with Anesthesia? YES NO If yes, explain: _____
Sudden Death in Childhood? YES NO If yes, explain: _____
Cancer? YES NO If yes, explain: _____

REVIEW OF SYSTEMS

Check **YES** for any symptoms that apply to you today:

General

Decreased Activity Yes
Decreased Appetite Yes
Fever Yes
Chills Yes

Skin

Acne Yes
Rash Yes
Scaling Yes
Itching Yes
Bruising Yes
Hair Changes Yes
Nail Changes Yes

Eyes

Dry Eyes Yes
Blurry Vision Yes
Double Vision Yes
Excess Tearing Yes

Ear/Nose/Throat

Tinnitus/Ringing Yes
Dizziness Yes
Hoarseness Yes
Sinus Trouble Yes
Nose Bleeds Yes

Respiration

Cough Yes
Short of Breath Yes
Wheezing Yes

Heart and Vascular

Palpitations Yes
Chest Pain Yes
Varicose Veins Yes
Difficulty Lying Down Yes

Gastrointestinal

Heartburn or Reflux Yes
Irritable Bowel Yes
Nausea Yes
Vomiting Yes
Diarrhea Yes
Constipation Yes

Genitourinary

Incontinence Yes
Urinary Infection Yes
Painful Urination Yes
Frequency Yes
Hesitancy Yes

Endocrine

Cold Intolerance Yes
Heat Intolerance Yes
Excessive Sweating Yes

Musculoskeletal

Joint Pain Yes
Back Pain Yes
Weakness Yes
Arthritis Yes
Cramping Yes

Neurologic

Headaches Yes
Seizures Yes
Tremor Yes
Numbness Yes
Tingling Yes

Psychiatric

Behavior Problem Yes
Anxiety Yes
Depression Yes
Mental Illness Yes

Hematalogic/Lymphatic

Swollen Nodes Yes
Bleeding Disorder Yes
Night Sweats Yes

Additional Symptoms --

SIGNED: Patient/ Legal Representative

____/____/____
DATE

PEDIATRICS OTOLARYNGOLOGY

DR. PATRICK J. O'DONNELL/DR. SUSAN TAN

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PLEASE PRINT

Patient Name: _____
(Last Name) (First Name) (MI)

Birth date: _____ Email address: _____ Nickname/Goes By: _____
(Optional)

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____
 please check box if same as above

Ethnicity: _____ Race: _____ Religion: _____ Language: _____
(ex: Chinese, White, Filipino, Hawaiian,) (ex: White, Asian, African American)

Referred by: _____ Primary Care Physician: _____

Mother/Guardian Name: _____ Birth date: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Separated: _____ (Please check one)

Address: _____ SSN: _____ (Tricare only)
(Street, City, State, Zip code) please check box if same as above

Home Phone: (____) _____ Work Phone : (____) _____ Ext: _____ Cell Phone: (____) _____

Employer _____ Employer Address: _____

Father/Guardian Name: _____ Birth date: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Separated: _____ (Please check one)

Address: _____ SSN: _____ (Tricare only)
(Street, City, State, Zip code) please check box if same as above

Home Phone: (____) _____ Work Phone : (____) _____ Ext: _____ Cell Phone: (____) _____

Employer _____ Employer Address: _____

Emergency Contact: _____ Relationship: _____
(Other than parents)

Address: _____ Contact Phone: (____) _____
(Street, City, State, Zip code) please check box if same as above

Insurance Authorization- Please Read and Sign

I hereby authorize Dr. O'Donnell/Dr. Tan to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. A copy of this signature is as valid as the original.

Note: All patients are expected to pay their portion of the bill within 30 days upon receipt of first statement. Cash, Check, money orders are all acceptable. If any problems are anticipated in paying the bill on time, please discuss the problem now.

Signature: _____ Date: _____

Print Name: _____