NYU Langone Medical Center

Division of Pediatric Otolaryngology
Scott M. Rickert MD, Director
160 East 32nd Street, New York, NY 10016
212-263-0922 (phone) / 646-501-5298 (fax)

GENERAL INFORMATION (FOR PATIENTS 12+ YEARS OF AGE)

Patient Name: _____
Last First MI (Nickname)

Mother's Name: _____ Father's Name: _____

Pediatrician: _____ Referring Physician: _____

Pharmacy: _____ Pharmacy Phone/Address: _____

Reason for Today's Visit: _____

Past Medical History: _____

Past Surgical History: _____

Hospitalizations: YES / NO if YES, explain: _____

Current Medications: _____

Medication Allergies: YES / NO if YES list medications: _____

BIRTH HISTORY

Born full term: YES NO Medical Problems at Birth: YES NO Ever been on a ventilator: YES NO

SOCIAL HISTORY

Do you smoke? YES, _____ packs/day NO, but I quit after_____ years, ____ packs/day NO, never

Do you drink alcohol? YES, _____ drinks/week NO, but I quit after_____ years, ____ drinks/week NO, never

Do you use illicit drugs? YES, which? _____ NO, but I used to use _____ NO, never

History of Family Illness: _____

Family history of anesthesia problems :		YES	NO	Family history of bleeding:	YES	NO
REVIEW OF SYSTEMS						
Fever		YES	NO	Issues with weight/nutrition/feeding	YES	NO
Genetic Disorder		YES	NO	if yes, explain: _____		
EYES	Double Vision	YES	NO	Glaucoma	YES	NO
CARDIOVASCULAR	Heart murmur	YES	NO	Heart problems/High Blood Pressure	YES	NO
EAR, NOSE, THROAT	Concern with hearing loss	YES	NO	Ear Pain/Ringing in Ears	YES	NO
	Balance Disturbance	YES	NO	Nosebleeds	YES	NO
	Nasal congestion/mouth breathing	YES	NO	Chronic nasal drainage	YES	NO
	Difficulty sleeping at night	YES	NO	Sinus problems	YES	NO
	Loud/Obstructive Snoring	YES	NO	Daytime Tiredness	YES	NO
	Increased work of breathing	YES	NO	Noisy Breathing or Stridor	YES	NO
	Voice Problems/Hoarseness	YES	NO	Problems with Speech/Speech Delay	YES	NO

Number of ear infections _____, tonsil infections _____, and sinus infections _____ in past 6 months

Number of ear infections _____, tonsil infections _____, and sinus infections _____ in past 12 months

MUSCULOSKELETAL	Arthritis	YES	NO	Chronic Back Pain	YES	NO
ENDOCRINE	Night Sweats	YES	NO	Weight Gain	YES	NO
GASTROINTESTINAL	Chronic Diarrhea	YES	NO	Heartburn/Reflux	YES	NO
HEMATOLOGY	Easy Bruising/Bleeding issues	YES	NO	Anemia	YES	NO
PULMONARY	Chronic Cough YES NO	Asthma YES	NO	Tuberculosis	YES	NO
NEUROLOGICAL	Headaches YES NO	Stroke YES	NO	Seizures	YES	NO
ALLERGY/IMMUN	Food Allergy YES NO	Tested YES	NO	Immunological Disorder	YES	NO
GENITOURINARY	Any bedwetting at home	YES	NO			
SKIN	Past skin cancer	YES	NO	Past Radiation Therapy	YES	NO
PSYCHIATRIC	Any psychiatric conditions	YES	NO	if yes explain: _____		

The above information is accurate to the best of my knowledge.

_____
Signature of Patient Date

I have reviewed the above information with the patient.

_____
Signature of Physician Date