Dr. Malis
FAMILY ENT & AUDIOLOGY

New Patient History Form

*** Please complete ALL the information; if Not Applicable, please write "N/A" ***

Date of your first visit with Dr. Malis: _____

Person Completing Form and Relationship: _____

Patient's Name: _____

Date of Birth: _____

Referring Physician: _____

Who Is Your Child's Pediatrician: _____

Has Dr. Malis seen any relatives/friends? O Yes O No

If "Yes", who: _____

Reason for today's visit: _____

Medication **ALLERGIES**: _____

Are your child's immunizations up to date? O Yes O No

Birth History

Birth Weight: _____

Fullterm: O Yes O No If early, born at how many weeks? _____

Any problems with pregnancy / delivery? O Yes O No

↳ If yes, what: _____

NICU Stay? O Yes O No

↳ If yes, how long? _____

Was your child on the ventilator? O Yes O No

↳ If yes, how long? _____

Breastfeed? O Yes O No If yes, how long? _____

Does your child take a bottle, "sippy" cup, or pacifier to bed? O Yes O No

Current Medications (Please list ALL)

_____ _____ _____

_____ _____ _____

Previous Hospitalizations /Surgeries (Month/Year)

_____ _____ _____

_____ _____ _____

Does your child or anyone in the family have problems with Anesthesia? O Yes O No

If yes, who and what was the problem? _____

Medical History

Please mark the circle if your child has / had any of the following medical problems?

- O Heart
  - Healthy / No Problems / Not Applicable
  - Congenital Heart Disease
  - Murmur
  - Needs antibiotics for dental procedures
  - Other; specify: _____
- O Lungs / Breathing
  - Healthy / No Problems / Not Applicable
  - Asthma
  - Recurrent Croup
  - Cystic Fibrosis
  - Bronchopulmonary Dysplasia
  - Laryngomalacia or Tracheomalacia
  - Other; specify: _____
- O Stomach / Bowel / Digestive
  - Healthy / No Problems / Not Applicable
  - Reflux
  - G-Tube
  - Other; specify: _____
- O Neurological
  - Healthy / No Problems / Not Applicable
  - Seizures
  - Cerebral Palsy
  - Hypotonia
  - ADD
  - ADHD

- Neurological Continued
  - Developmental Delay
  - Autism
  - Other; specify: _____
- Skin
  - Healthy / No Problems / Not Applicable
  - Eczema
  - Birthmarks (e.g. Hemangiomas, Café Au Lait spots, etc)
  - Other; specify: _____
- Eyes
  - Healthy / No Problems / Not Applicable
  - Strabismus
  - Glasses / Contacts
  - Other; specify: _____
- Endocrine
  - Healthy / No Problems / Not Applicable
  - Thyroid Disease
  - Diabetes
  - Obesity
  - Other; specify: _____
- Blood
  - Healthy / No Problems / Not Applicable
  - Bleeding Disorder
  - Sickle Cell Disease / Trait
  - Other; specify: _____
- Kidney
  - Healthy / No Problems / Not Applicable
  - Recurrent Urinary Tract infections
  - Other; specify: _____
- Allergy / Immunology
  - Healthy / No Problems / Not Applicable
  - Immune Deficiency
  - Seasonal Allergies / “Hayfever”
  - Other; specify: _____

O Other medical problems not listed above; please specify:

_____

Family History

Please mark the circle if a family member has / had any of the following medical problems:

O Healthy / No Problems / None Applicable

O Bleeding problems

O Sickle Cell Disease

O Seasonal Allergies

O Ear, Nose, or Throat problems

O Other; specify: _____

Social History

Is your child in daycare? O Yes O No

If yes, started when? _____

Hours per day _____

Days per week _____

Average number of children in the daycare _____

Is your child in school? O Yes O No

Grade _____ Name of school _____

Does any family member smoke? O Yes O No

Who? _____

Do they smoke in the house? O Yes O No

In the car? O Yes O No

Child lives with: _____

Legal Guardian Name(s): _____