Center for NEUROSCIENCES

EAR & HEARING
Otology I Neurotology I Audiology

Date:
Patient Name:
Account Number:
DOB:

Abraham Jacob, MD
Pediatric Otology
Initial Visit

What is the MAIN problem you are here to see us for today? _____

PAST MEDICAL HISTORY / BIRTH HISTORY:

1) PLEASE ANSWER THE FOLLOWING:

WHAT WAS THE CHILD'S GESTATIONAL AGE AT DELIVERY: _____ WEEKS **BIRTH WEIGHT:** _____

METHOD OF DELIVERY: ☐ VAGINAL ☐ CAESAREAN SECTION ☐ OTHER _____

WAS A NEWBORN HEARING TEST PERFORMED? ☐ YES ☐ NO RESULTS: _____

2) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE IF PATIENT HAS / HAD ANY OF THE FOLLOWING ILLNESSES: FOR "YES" ANSWERS, PLEASE EXPLAIN:

	YES	NO			YES	NO	
INFECTIONS DURING PREGNANCY	❑	❑	_____	**KIDNEY PROBLEMS**	❑	❑	_____
COMPLICATION DURING PREGNANCY	❑	❑	_____	**NEUROLOGICAL PROBLEMS**	❑	❑	_____
HEART PROBLEMS	❑	❑	_____	**IMMUNE DEFICIENCY**	❑	❑	_____
BLEEDING DISORDER	❑	❑	_____	**ALLERGY PROBLEMS/THERAPY**	❑	❑	_____
RESPIRATORY PROBLEMS	❑	❑	_____	**IMMUNIZATIONS UP TO DATE**	❑	❑	_____
SIGNIFICANT INJURY (IES)	❑	❑	_____	**OTHER MEDICAL PROBLEMS**	❑	❑	_____

3) PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (AND DATES) YOU HAVE EVER HAD (INCLUDING TONSILS & ADENOIDS):

SURGERIES/HOSPITALIZATIONS	YEAR	SURGERIES/HOSPITALIZATIONS	YEAR

ANESTHESIA PROBLEMS: ☐ **YES** ☐ **NO**

4) PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE AND TIMES PER DAY): **PLEASE INCLUDE OVER-THE COUNTER MEDICATIONS**

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

5) LIST ANY **ALLERGIES** TO MEDICATIONS:

6) PLEASE INDICATE ANY SPECIAL THERAPY (IES): ☐ SPEECH THERAPY ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ OTHER

SOCIAL HISTORY:

DOES THE CHILD ATTEND DAY CARE? ☐ YES ☐ NO **SCHOOL GRADE:** _____ **HEARING IMPAIRED CLASSES:** ☐ YES ☐ NO

WITH WHOM DOES THE CHILD LIVE? _____

IS THE CHILD EXPOSED TO CIGARETTE SMOKE? ☐ YES ☐ NO

CAFFEINE INTAKE: _____ PER DAY **EXERCISE:** ☐ YES ☐ NO **TYPE/FREQUENCY:** _____

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FAMILY HISTORY:

1) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE WHETHER ANY RELATIVES HAVE ANY OF THE FOLLOWING ILLNESSES/PROBLEMS:

2) FOR "YES" ANSWERS, PLEASE INDICATE WHICH RELATIVE(S) HAS/HAVE THE PROBLEM AND EXPLAIN

	YES	NO	
HEARING LOSS	☐	☐	_____
BLEEDING DISORDER	☐	☐	_____
CANCER	☐	☐	_____
HEART DISEASE	☐	☐	_____
DIABETES	☐	☐	_____
ANESTHESIA PROBLEMS	☐	☐	_____
OTHER MEDICAL PROBLEMS	☐	☐	_____

REVIEW OF SYSTEMS:

1) Please check the "Yes" or "No" box to indicate whether the patient has any of the following symptoms:

2) For any "Yes" answers, please check the "Current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
GENERAL	Fever	☐	☐	☐	Weight loss ☐ or gain ☐	☐	☐	☐
EYES	Wear glasses	☐	☐	☐	Injuries/Trauma	☐	☐	☐
CARDIOVASCULAR	Swelling of feet	☐	☐	☐	Irregular pulse	☐	☐	☐
RESPIRATORY	Chronic cough	☐	☐	☐	Noisy breathing	☐	☐	☐
NEUROLOGICAL	Fainting	☐	☐	☐	Chronic headache	☐	☐	☐
PSYCHIATRIC	Depression	☐	☐	☐	Anxiety	☐	☐	☐
	Schizophrenia	☐	☐	☐	Manic/Depression	☐	☐	☐
SKIN	Rash	☐	☐	☐	Itching	☐	☐	☐
	Hives	☐	☐	☐	Birth marks	☐	☐	☐
MUSCULOSKELETAL	Joint pain	☐	☐	☐	Muscle pain	☐	☐	☐
GI	Nausea	☐	☐	☐	Vomiting	☐	☐	☐
ENDOCRINE	Excessive thirst	☐	☐	☐	Feel warmer than others	☐	☐	☐
	Feel cooler than others	☐	☐	☐				
HEME/LYMPH	Swollen glands	☐	☐	☐	Bleeding problems	☐	☐	☐
ALLERGY	Food allergies	☐	☐	☐	Inhalant allergies	☐	☐	☐
ENT	Ear pain	☐	☐	☐	Ear drainage	☐	☐	☐
	Ear pressure	☐	☐	☐	Recurrent ear infections	☐	☐	☐
	Hearing loss	☐	☐	☐	Tinnitus/Ear noises	☐	☐	☐
	Imbalance	☐	☐	☐	Vertigo / Spinning	☐	☐	☐
	Hoarseness	☐	☐	☐	Sore throat	☐	☐	☐
	Snoring with pauses	☐	☐	☐	Recurrent throat infections	☐	☐	☐
	Nasal congestion	☐	☐	☐	Wear hearing aid (s)	☐	☐	☐

REVIEWED BY: _____ DATE: _____

ABRAHAM JACOB, MD
OTOLOGY, NEUROTOLOGY & CRANIAL BASE SURGERY