Date of visit:_____ Name:_____

DIVISION OF PEDIATRIC OTOLARYNGOLOGY
NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT OR CAREGIVER

Mother's name _____
Occupation _____
Father's name _____
Occupation _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____
_____

A. PREGNANCY AND BIRTH:

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron supplements? No Yes
4. Was the baby on time? Yes No
5. What was the birthweight? _____
6. Did the baby have any trouble breathing? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes
   What kind? _____
   _____

B PAST MEDICAL HISTORY:

1. Does your child have a regular pediatrician? Yes No
   Who? _____
2. Has your child had allergic reactions to any medications, foods, or insect bites? No Yes
   Which ones? _____
3. Any hospitalizations other than for birth? No Yes
   For what? _____
4. Any serious injuries? No Yes
   What kind? _____
5. Are any medications taken regularly? No Yes
   Which ones?_____

C. FAMILY HISTORY

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex, and general health of brothers and sisters _____
   _____
   _____
4. Have any of your children died? No Yes

D. NUTRITION AND IMMUNIZATIONS

1. Is your child's appetite usually good? Yes No
2. Does he/she take vitamins? Yes No
3. Is your child up-to-date on immunizations? Yes No

E. REVIEW OF SYSTEMS:

a. Has your child had frequent ear infections? No Yes
b. Any eye problems? No Yes
c. Does he/she have frequent colds or sore throats? No Yes
d. Is there asthma, pneumonia, or recurrent cough? No Yes
e. Does he/she have a heart murmer or any heart problems? No Yes
f. Any problems with urination? No Yes
g. Any problems with diarrhea or constipation? No Yes
h. Have there been any convulsions or other problems with the nervous system? No Yes
i. Any eczema, hives, or other skin conditions? No Yes
j. Has your child ever been anemic? No Yes
k. Please list any other medical problems: _____
   _____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1½ years old? Yes No
4. Does he/she have any trouble sleeping? No Yes
5. Has he/she had any trouble in school? No Yes
6. Circle if your child has had any of the following: thumb sucking, bed wetting, bad temper, hyperactivity, nightmares, speech problems, other

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Does your child always wear a helmet when riding his/her bicycle? Yes No

Please do not write below this line. Thank you!

Reviewed & Updated by Physician: Signature & Date	

SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

UNIVERSITY PHYSICIANS BROOKLYN, INC.

Office location: ☐ UPB-ENT 185 Montague St ☐ UPB-ENT 376 6th Ave ☐ SUNY Suite H

DIVISION OF PEDIATRIC OTOLARYNGOLOGY **REGISTRATION RECORD**	**TO BE FILLED OUT BY PARENT OR CAREGIVER**

CHILD'S NAME _____ ☐ BOY ☐ GIRL
LAST FIRST MIDDLE

CHILD's BIRTHDATE _____ CHILD'S SOCIAL SECURITY # _____

MOTHER / FATHER / GUARDIAN _____ BIRTHDATE _____

MOTHER / FATHER / GUARDIAN _____ BIRTHDATE _____

HOME ADDRESS _____ APARTMENT # _____

CITY, STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE or BEEPER _____

WORK PHONE (Mom) _____ WORK PHONE (Dad) _____

Email Address (Mom)_____ **Email Address (Dad)**_____

INSURED'S NAME _____
LAST FIRST MIDDLE

INSURED'S DATE of BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER NAME _____

EMPLOYER'S ADDRESS _____

PRIMARY INSURANCE _____ POLICY # _____

OTHER INSURANCE _____ POLICY # _____

My signature below indicates that I am requesting care in this office and consent to medical treatment. I authorize Dr. _____ to release medical information to the primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I have insurance coverage with the above named company and assign directly to the physician all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chanrges whether or not paid by insurance.

SIGNATURE _____ DATE _____

RELATIONSHIP to PATIENT _____

How were you referred to the Division of Pediatric Otolaryngology?
- ☐ by my child's primary care physician
- ☐ by a different physician
- ☐ by a friend or relative
- ☐ by my insurance or managed care program
- ☐ other _____

Information Verified By:

_____ _____

_____ _____

_____ _____
Initials Date

FOR STAFF USE ONLY

NAME OF REFERRAL SOURCE (if applicable) _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ PHONE _____

FOR STAFF USE ONLY

Patient ID # _____