

Albany ENT & Allergy Services

400 Patroon Creek Boulevard, Suite 205
Albany, New York 12206

518 701 2000

Pediatric
Patient Health Care Survey
(For patients Age 12 and Younger.)

Patient Name			Date of Birth	Social Security #	Gender <input type="radio"/> Female <input type="radio"/> Male
Street Address			City, State and Zip		
Home Phone	Work Phone	Cell Phone	Preferred Contact Number <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell		Email Address
Name of Emergency Contact		Relationship	Phone Number	Employer	Employer Phone

Guarantor's Name		Relation to Patient	Date of Birth	Phone Number
Address			City State and Zip	

Health Insurance Information **Is your child covered by insurance?** Yes No

If Yes, please list all medical coverages for which he/she is eligible below.

Primary Insurance Name		Primary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
Primary Insurance Policy Holder			Policy Holder Date of Birth	Relation to Patient	
Secondary Insurance Name		Secondary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
Secondary Insurance Policy Holder			Policy Holder Date of Birth	Relation to Patient	

Please List other Medical Providers your child is seeing currently:

Primary Care Physician Name	PCP Phone	Provider 2 Name	Provider 2 Phone
Provider 3 Name	Provider 3 Phone	Provider 4 Name	Provider 4 Phone

How did you hear about our office?

Is today's visit related to a No Fault or Disability Injury? Yes No

If Yes please describe the injury and how it happened below:
--

Is today's visit about an injury that related to: Motor Vehicle Accident Altercation

Were you referred to our office by: Emergency Room Primary Care Other

Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to Albany ENT & Allergy Services PC and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company and health care provider(s).

Signature of Patient or Guarantor: _____ **Date:** _____

Past Medical & Surgical History

Patient Name	Date of Birth
--------------	---------------

Allergy/Immunology

Allergies (Not Related to Medications) Yes No

If Yes, Please Mark/Describe

- Adhesive Tape Bees/Insects Eggs Environmental
 Food Latex Milk Peanuts
 Seafood Seasonal

Others:

Reaction to Anesthesia? Yes No

- General Local

If Yes, describe

Reaction to X-Ray Dye? Yes No

If Yes, describe

Atopic Eczema Yes No

Contact Dermatitis Yes No

Eczema/Psoriasis Yes No

Hay Fever Yes No

Immunizations - Up to Date? Yes No

Juvenile Rheumatoid Arthritis Yes No

Birth and Developmental History

Complete this Section for Patients Age 1 - 3

Anemia Yes No

Developmental Milestones

Turns to Sound (4 Months) Yes No

Responds to Name (6 Months) Yes No

Mama/Dada (9 Months) Yes No

Walk Alone (12 month) Yes No

Two Word Sentence - (2 Yrs) Yes No

Full Term Healthy Infant Yes No

If no, describe

Infections at Birth Yes No

If yes, describe

ICU Admission Yes No

NICU Stay Yes No

If yes to ICU or NICU describe

Passed Hospital Hearing Screen Yes No

Other Birth History

Cardiovascular

Cardiac Arrhythmia Yes No

Heart Murmur Yes No

/Mitral Valve Prolapse Yes No

If Yes, Do you require antibiotic prophylaxis for procedures? Yes No

Patent Ductus Arteriosus (PDA) Yes No

Genetic

Cystic Fibrosis Yes No

Down's Syndrome Yes No

Turner's Syndrome Yes No

Dermatologic

Birth Mark Yes No

Hives/Urticaria Yes No

Ear, Nose & Throat

Adenoidectomy Yes No

Ear Infections Chronic Recurrent Yes No

Ear Wax, Recurrent Yes No

Ear Tubes Yes No

Frenulectomy Yes No

Hearing Loss Yes No

Nasal Fracture Yes No

Other Ear Surgery Yes No

Perforated Ear Drum Yes No

Swimmer's Ear Yes No

Tonsil Enlargement Yes No

Tonsillectomy Yes No

Tonsillitis Yes No

Upper Respiratory Infections, Frequent Yes No

Sinusitis Yes No

Vocal Cord Nodules Yes No

Gastrointestinal

Appendectomy Yes No

Food Sensivity Yes No

Chronic Constipation Yes No

Formula Intolerance Yes No

GERD Yes No

Hernia Yes No

Hernia Repair Yes No

Jaundice Yes No

Lactose Intolerance Yes No

Heartburn/Reflux Yes No

Obesity Yes No

Hepatitis Yes No

Stomach Ulcer Yes No

Hematology

Anemia Yes No

Bleeding Disorder Yes No

Sickle Cell Anemia Yes No

Hemophilia Yes No

Sickle Cell Trait Yes No

Thalassemia Yes No

Infectious

Croup Yes No

HIV Yes No

Lyme Disease Yes No

Methicillin-Resistant Staphylococcus Aureus (MRSA) Yes No

Pertussis Yes No

Respiratory Syncytial Virus (RSV) Yes No

Metabolic/Endocrine

Diabetes Mellitus Type I Yes No

Obesity Yes No

Past Medical History (continued)

Neurology

- ADD/ADHD Yes No
Autism/Autism Spectrum Disorder Yes No
Developmental Delay Yes No
Headaches Yes No
Seizure Disorder/Epilepsy Yes No
Scoliosis Yes No
Tourette's Syndrome Yes No

Patient Name	Date of Birth
--------------	---------------

Pulmonary

- Asthma Yes No
Aspiration Pneumonia Yes No
Bronchitis Yes No
Laryngospasm Yes No
Pneumonia Yes No
Misc
Tooth Decay Yes No

Past Birth or Medical History Not Listed Above (Use back of page to continue if needed)

Home Environment & Habits

Is there secondhand smoke exposure at home? Yes No

Are there animals in the home? Yes No If Yes, Dog Cat Bird

Other Pets

Home Heating and Cooling:

Gas Hot Air Electric Wood Air Conditioning at Home? Yes No If Yes, Central Air Room

Oil Propane Solar Other Heat

Does your child sleep well on a regular basis? Yes No

If no, describe

Does your child drink beverages containing caffeine? Yes No

If Yes, how much?

Does your child drink water on a daily basis? Yes No

Amt Per Day

Does your child attend day care? Yes No

Pre School Age Children Only

If Yes, how many days per week?

Medications & Allergies

Is your child currently taking any medications? Yes No

If Yes, Please List Current Medications Below (over the counter and prescription) Use back of page for additional room.

Does your child have any medication allergies? Yes No

If Yes, Please List all Known Allergies below:

Local Pharmacy

Mail Order Pharmacy

Local Pharmacy Name	Local Pharmacy Phone	Mail Order Pharmacy Name	Mail Order Pharmacy Phone

Parent or Guardian's Signature: _____ Date: _____