

William B. Cobb, M.D., P.A.

Ewen Y. Tseng, M.D., P.A.

Keith E. Matheny, M.D.

CHILD EAR HISTORY

Name: _____ Date: _____

Please answer the questions carefully. CIRCLE THE ANSWER AND PRINT LEGIBLY.

- 1. Why are you here to see the doctor?
2. Does your child have:
a. EAR PAIN (earache)
b. EAR DRAINAGE:
c. HEARING LOSS:
d. DIZZINESS OR BALANCE PROBLEM?
e. SPEECH PROBLEM?
3. How many times in the last year has your physician treated an EAR INFECTION?
4. Has your child persisted with MIDDLE EAR FLUID after his infection has cleared?
5. What medical treatment has your child had to treat his infections?
6. Are there other children in the family with a history of ear infection?
7. Does your child:
8. Are there any diseases that run in your family?
9. Childhood Diseases:
10. Has your child had SURGERY of any kind?
11. Has your child ever been HOSPITALIZED?
12. Is your child ALLERGIC to Penicillin?
13. Is he on any PRESENT MEDICATION?