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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) ..... Yes No
      How long has it been present? _____ days _____ weeks _____ months _____ years
      Location: Left Right Both ears
      Frequency of Attacks: _____ x a month _____ x a year
   b. EAR DRAINAGE: ..... Yes No
      How long has it been present? _____ days _____ weeks _____ months _____ years
      Location: Left Right Both ears
      Duration: Continual Intermittent
      Character: Clear White Yellow Bloody
      When did it last occur? _____
   c. HEARING LOSS: ..... Yes No
      How long has it been present? _____ days _____ weeks _____ months _____ years
      Duration: Continual Fluctuating
      Location: Left Right Both ears
- Onset: Sudden Gradual
      What do you think caused it? Infection, Noise Exposure, Injury,
      Persistent middle ear fluid
      Congenital. Hereditary, Radiation
      Hole in eardrum, Other
      Has a hearing test been performed? ..... Yes No
      Results: _____
   d. DIZZINESS OR BALANCE PROBLEM? ..... Yes No
   e. SPEECH PROBLEM?
      Did your child make the usual babbly sounds that babies make? ..... Yes No
      At what age did he say his first words? _____
      Approximately how many words does he say now? _____
      Does he pronounce his words correctly? ..... Yes No
      Does your child talk in sentences? ..... Yes No
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? ..... Yes No
5. What medical treatment has vour child had to treat his infections? _____
6. Are there other children in the family with a history of ear infection? ..... Yes No
7. Does your child:
   Snore at night? ..... Yes No
   Sleep with his mouth open? ..... Yes No
   Have frequent sore throats - with or without fever? ..... Yes No
   Have a blocked nose? ..... Yes No
   Sneeze often? ..... Yes No

Have enlarged or tender areas in his neck? ..... Yes No

8. Are there any diseases that run in your family? ..... Yes No
   If so, what diseases: _____
9. Childhood Diseases:

Meningitis	Diphtheria
Encephalitis	Polio
Mumps	Rubella (German measles)
Whooping Cough	Seizure disorder
Measles	RH disorder
Chicken Pox	Bleeding disorder
Scarlet Fever	

10. Has your child had SURGERY of any kind? ..... Yes No
    If so, what types: _____
11. Has your child ever been HOSPITALIZED? ..... Yes No
    If so, when and what for: _____
12. Is your child ALLERGIC to Penicillin? Yes No Any other medicine?. ..... Yes No
    Specify: _____
13. Is he on any PRESENT MEDICATION? ..... Yes No
    Specify: _____