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MOUTH, THROAT, NECK

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 or do you have FREQUENT SORE THROATS? .... Yes…………No

When did they begin? ______________________________

How many times in the past year have they been treated with an antibiotic? ____________ How many times in the previous year? ____________ How many times 2 years ago? ____________

CHARACTERISTICS OF SORE THROAT (circle all that are applicable)

- Oral temperature 101 ° or higher
- Enlarged tender lymph nodes in neck
- Coating on tonsils
- Positive culture for strep
- Increasing severity of attacks each year
- increasingly difficult to clear with an antibiotic
- Persistent enlargement of lymph nodes in neck longer than 6 months
- Attacks causing significant absence from school or work
- Stertorous breathing or mouth breathing
- Persistent infection in tonsils despite appropriate antibiotic therapy
- Difficulty or pain with swallowing

3. Have you ever had an ABSCESS OF YOUR TONSIL requiring surgical drainage? .... Yes……….No
4. Does your child or do you have: (circle all applicable)
   - Recurrent middle ear infections
   - Persistent middle ear fluid
   - Hearing loss
   - Persistent nose obstruction, not due to allergies, manifested by mouth breathing
   - Nasal speech
   - Regurgitation of fluids or foods through nose when swallowing

IF YOU HAVE A PROBLEM OTHER THAN THROAT INFECTIONS, COMPLETE THE FOLLOWING; OTHERWISE, COMPLETE GENERAL MEDICAL HISTORY BELOW.

5. Do you have: (please circle)

Pain		Lips	Palate
Bleeding		Gums	Throat
Change in appearance	of	Teeth	Saliva glands
Change in function		Mouth (floor)	Neck
Enlargement or growth		(sides)	Larynx (voice box)
		Tongue	

Describe: ______________________________

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How long has it been present? ______________________________

Duration of attack: Continual Intermittent

What do you think caused it? ______________________________

Any associated symptoms? (please circle)

Speech change	Bringing up blood
Swallowing change	Weight change
Breathing change	Sensation of foreign body
Hoarseness	
Cough	Other: ____________________
Choking	

GENERAL MEDICAL HISTORY

6. Are you presently taking any medicines? Yes No If so, what? ____________________
7. Do you smoke? __________ How many packs a day? __________ For how long? __________
8. Are you allergic to Penicillin? Yes No Any other medication? ____________________
9. Have you ever had any surgery? Yes No When, and what? ____________________
10. Any other hospitalizations? Yes No When, and for what? ____________________
11. Have you ever had any of the following diseases? When? (circle/date)

Heart attack	Polio	Tuberculosis	Rheumatic fever
Stroke	Meningitis	Pneumonia	Cancer
Yellow jaundice	Encephalitis	Free bleeding in family	Bleeding disorder
Diabetes	Malaria	Nerve or psychiatric illness	
High blood pressure	Arthritis	Asthma	
Chest pain after exercise	Heart murmur	Thyroid disease	
Ulcer or stomach disease	Syphilis	Mumps	
Lung disease	Chicken pox	Diphtheria	
Scarlet fever	Red measles	German measles	

12. If following deceased; of what:
    - Mother
    - Father
    - Brother(s)
    - Sister(s)
13. Please use the following space to more completely explain or elaborate your history ____________________

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