Pediatric Specialists of Virginia
Children's National. INOVA
3023 Hamaker Court, Suite 500
Fairfax, Virginia 22031
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Patient Label

NEW PATIENT QUESTIONNAIRE
OTOLARYNGOLOGY

Patient Name: ____ Date: ____________________________________

Who is filling out this form? ____

Who lives in the home? ____

What ear, nose, or throat problem is your child having? ____

How long has your child had this problem? ____

What symptoms does your child have? ____

Does your child have any developmental (growing) problems? ____

How many words does your child say? ____

List the names and dates of all antibiotic medicines your child has taken. ____________________________________

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Does your child have any of the following?

	Circle	Comments
Allergies	Yes/No	
Had allergy testing	Yes/No	
Failed hearing test	Yes/No	
Contact with tobacco products	Yes/No	
Enrolled in speech therapy	Yes/No	
Regular ear infections	Yes/No	How many the last 6 months? _____ or 12 months? _____
		□Right ear? □Left ear? □Both?
Regular sore throat	Yes/No	How many the last 6 moths? _______ or 12 months? ____
Positive strep test	Yes/No	
Ear drainage	Yes/No	
Admitted in hospital	Yes/No	Reason: ENT problem?
Surgery	Yes/No	
Headaches	Yes/No	
Sleep apnea	Yes/No	Gasps? Pauses in breathing? Restless sleep? Morning headaches? Daytime sleepiness? Mood changes?
Weight gain	Yes/No	

Continued →

Birth history:

Was your child born on the due date? ___________

If not, was it before or after the due date? ________________ By how much? _______________________

Was your child given breast milk? ____

Was your child in daycare? ____

Does your child have a history of reflux? ____

Tell us your biggest concern: ____

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