OFFICE USE ONLY scanned _____

BLEEDING HISTORY QUESTIONNAIRE

Starfish Pediatric ENT OF CHARLESTON

CHECK the appropriate YES or NO box

A. PERSONAL HISTORY:

1. Has your child ever had surgery, stitches for trauma or a broken bone? ❍ Y ❍ N
   - If YES, did your child experience bleeding during or after the procedure? ❍ Y ❍ N
   - What was the procedure? _____
2. Does your child bruise easily compared to normal? ❍ Y ❍ N
3. If a boy, did your child bleed after circumcision? ❍ Y ❍ N
4. Did he/she bleed after the umbilical cord came off? ❍ Y ❍ N
5. Has your child had frequent nosebleeds? ❍ Y ❍ N
6. Has your child bled after tooth extractions, wisdom tooth surgery or with the loss of baby teeth? ❍ Y ❍ N
7. Is your child taking any of the following:
   - Aspirin ❍ Y ❍ N
   - ibuprofen products ❍ Y ❍ N
   - antihistamines ❍ Y ❍ N
8. Is there any history of heavy menstrual periods? ❍ Y ❍ N

B. FAMILY HISTORY

1. Are there women in your family (mother, aunt, sister, grandmother) who have had monthly periods requiring either iron therapy or transfusions? ❍ Y ❍ N
2. Is there anyone in the family with a history of frequent nosebleeds judged to be severe or requiring a blood transfusion? ❍ Y ❍ N
3. Is there anyone in your family who bled after tooth extractions, wisdom tooth surgery or loss of baby teeth? ❍ Y ❍ N
4. Has anyone in the family required a blood transfusion? ❍ Y ❍ N
   - Who? _____
   - Reason for transfusion? _____
5. Has anyone in the family been called a free bleeder? ❍ Y ❍ N
   - Who? _____
6. Has anyone in your family ever bled after tonsil surgery, childbirth, or other operations? ❍ Y ❍ N
7. Is there anyone in the family with hemophilia, Von Willebrand disease, low platelets or ITP (Idiopathic thrombocytopenia purpura)? ❍ Y ❍ N
   - Who? _____
   - Diagnosis? _____

Starfish Pediatric ENT
OF CHARLESTON

CURRENT MEDICATIONS (please include name, dose and frequency taken)

_____ _____

_____ _____

Do you have any ALLERGIES TO MEDICATIONS? _____ YES _____ NO

Medication: _____ Reaction:_____

additional:_____

BIRTH HISTORY

Was child born prematurely? YES NO If Yes, by how many weeks? _____ child's birth weight? _____

Has your child ever needed a breathing tube or ventilator? _____ YES _____ NO

Did you child pass their newborn hearing screening test? _____ YES _____ NO

SOCIAL HISTORY

Is your child currently in day care? YES NO

Is your child in school? K 1 2 3 4 5 6 7 8 9 10 11 12

Is your child exposed to tobacco smoke? YES NO

Pets in the home? YES NO type_____

FAMILY HISTORY (please check all that apply to your family members)

_____allergy

_____asthma

_____cystic fibrosis

_____ear infections

_____hearing loss or deafness

_____bleeding disorder

_____problems with anesthesia

_____thyroid disease

_____cancer (type:_____)

OTHER: _____

PLEASE SIGN BELOW

I certify that the above information is true and correct.

Parent/Guardian Name:_____X_____

----------BELOW THIS LINE FOR STAFF ONLY----------

Reviewed by: _____ M.D. Date: _____

Temp _____ BP _____/_____ Pulse _____ Sat _____ Resp _____ Weight _____ Height ___ ___

H/P/A/P: _____

_____

_____

_____

_____

_____

_____

PLAN:_____SCANNED____

Starfish Pediatric ENT
OF CHARLESTON

NEW PATIENT QUESTIONNAIRE

Patient Name: _____DOB_____ Age: _____

Pediatrician: _____ Referring Physician (if different):_____

Pharmacy: _____ ADDRESS: _____

Reason for Today's Visit - please list all concerns you wish to discuss with the doctor today:

_____

_____

_____

ENT SYMPTOMS

Circle any of the following symptoms that pertain to your child:

Snoring	Noise in Ears	Sinus Infections
Gasping for breath during sleep	Off-Balance	Sensitive to Light
Breathing Obstruction	Earache	Abnormality of Smell
Hoarseness	Noisy Breathing	Sore Throat
Cough	Congestion or Stuffiness	Lump in Neck
Difficulty Swallowing	Runny Nose Constant	Mouth Ulcers
Right/Left Ear Hearing Loss	Postnasal Drip Periodic	Heartburn
Drainage or Bleeding from ear/s	Nosebleeds	HEADACHE
Dizziness (Spinning Sensation)	Broken Nose	Mouth-breathing

Review of Body Systems

Patient currently having problems with any of the following:

Eyes Yes No	Stomach Problems Yes No	Epilepsy/Seizures Yes No
Bleeding Problems Yes No	Joint Aches/Pains Yes No	Heart Problems Yes No
Lungs, Breathing Yes No	Bowel Movements Yes No	Hepatitis Yes No
Numbness/Tingling Yes No	Depression, Anxiety, etc. Yes No	Appetite/Weight Change Yes No
Diarrhea Yes No	Bladder Problems Yes No	

PAST MEDICAL HISTORY

Does your child have or have they been treated for any of the following (check all that apply)?

_____AIDS/HIV
_____allergies
_____asthma
_____reflux
_____noisy breathing
_____sleep apnea
_____hearing loss
_____ear disease
_____bleeding disorder
_____sickle cell anemia
_____tuberculosis (TB)
_____seizures
_____heart disease
_____lung disease
_____kidney disease
_____meningitis
_____cancer (type:_____)
_____transplant (type:_____)
_____other:_____

HOSPITALIZATIONS (please list):_____

SURGERIES (please list):_____