Zaher Srour, M.D.

Advanced Otolaryngology & Allergy, LLC

Ear, Nose, Throat - Facial Plastic & Reconstructive Surgery

864 Broadway, Hanover, PA, 17331 **www.HanoverENT.com** **Tel:717-632-2221**

MEDICAL HISTORY-Ages 5-18

Name: _____ M F Age: _____ DOB:____/____/_____

Reason for Visit: _____

_____Height:_____Weight: _____

Family Doctor: _____Referring Doctor: _____

PLEASE CHECK ☑ WHERE APPLICABLE

General	**Ears** R- right L-left		**Mouth**	**Nose**
☐Weakness ☐Fatigue ☐Chills ☐Night Sweats ☐Weight Loss ☐Weight Gain ☐Obesity	☐Drainage ☐Pain ☐Itching ☐Ear infection ☐ Imbalance ☐ Dizziness ☐Exposure to Loud Noises from	**R L** **R L** **R L** **R L** ☐ Music ☐Firearms	☐Sore Throat / Pain ☐Sores/Ulcers ☐Bleeding ☐Difficulty Swallowing ☐Painful Swallowing ☐Mouth Breathing ☐Snoring ☐Sleep Apnea ☐Enlarged tonsils	☐Congestion ☐Nose blockage ☐Nosebleed ☐Sneezing ☐Runny Nose : ☐Clear ☐Yellow ☐Green ☐Sinusitis

Throat-Voice	**Neck**	**Respiratory**	**Eyes**
☐Hoarseness ☐Change Of Voice ☐Frequent Clearing ☐Noisy Breathing ☐Croup	☐Pain ☐Lump/Masses ☐Swollen Glands	☐Cough ☐ Asthma ☐Wheezing ☐Shortness of breath	☐Blurred Vision ☐Tearing ☐Itching ☐Pain

Neuro /Psych	**Gastro-GI**	**DEVELOPMENT**	**Cardiovascular**	**Infectious** :
☐Seizures ☐Tremor ☐Loss of consciousness ☐Depression	☐Reflux ☐Pain while eating ☐Difficulty eating ☐Regurgitation ☐Trouble eating	☐ Motor Difficulty ☐ Speech difficulty ☐ Poor language ☐ Difficulty walking ☐ Imbalance	☐Irregular Heart ☐Congenital heart conditions ☐Easy Bruising ☐Easy Bleeding	☐HIV ☐Hepatitis ☐Tuberculosis ☐Transfusion

Skin:	**Other health conditions :**
☐Hives ☐Eczema ☐Lesions ☐Cancer ☐Warts ☐Scaring	

PAST MEDICAL & SOCIAL HISTORY

School Grade			
In-House Smoking	□Never	□Occasional	□Daily
Smoking	□Never	□Occasional	□Daily
Allergy Testing	□No	□Yes, When :	
Allergies	□**Medication:** □**Environmental:** □**Food :**		□Not Known □Not Known □Not Known
Surgeries	□Tonsils □ Adenoids □Ear Tubes □Neck Surgery Other Surgeries:		
Major Illnesses & Hospitalization			

FAMILY HISTORY

Lives with	□ Mother/Father □Foster home □Grandparents □ Other:	
Father	□Alive	□Passed Away Due to :
Mother	□Alive	□Passed Away Due to :
Siblings	□How many :	□Health problems:

*I do acknowledge the receipt of Notice of Privacy Practices for "Advanced Otolaryngology & Allergy, LLC"

*I give my permission to release **FULL** medical information to other individuals:

□ NO □ YES To _____ Relationship: _____

To _____ Relationship: _____

*I give my permission to leave medical information on **answering machine** or **voicemail**: □ NO □ YES

*If you want to specify the information that can be shared with **other people** or on answering machine/voicemail to:_____

*Medication history consent: I authorize any associated physician, physician assistant or delegated staff member of AOA permission to view my prescription history from external source. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: ___/___/____

RELATIONSHIP TO PATIENT: _____