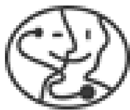

Zaher Srour, M.D.

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- Child Ages 0-5

Name: ________________________________ **M** **F** **Age:** _____ **DOB:**____/____/_______

Reason for Visit: ____

____ **Height:**__________ **Weight:** __________

Problems at birth: ____

PLEASE CHECK ☑ WHERE APPLICABLE

General	Ears	R- right L-left	Mouth	Nose
☐Weakness	☐Drainage	R L	☐Sore Throat / Pain	☐Congestion
☐Fatigue	☐Pain	R L	☐Sores/Ulcers	☐Nose blockage
☐Chills	☐Itching	R L	☐Bleeding	☐Nosebleed
☐Night Sweats	☐Ear infection	R L	☐Difficulty Swallowing	☐Sneezing
☐Weight Loss	☐Ear pulling	R L	☐Painful Swallowing	☐Runny Nose :
☐Weight Gain	☐ Imbalance		☐Mouth Breathing	☐Clear
			☐Snoring	☐Yellow
			☐Sleep Apnea	☐Green

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

Neuro /Psych	Gastro-GI	DEVELOPMENT	Cardiovascular	Infectious :
☐Seizures	☐Reflux	☐ Motor Difficulty	☐Irregular Heart	☐HIV
☐CP (Palsy)	☐Spitting	☐ Speech difficulty	☐Congenital heart conditions	☐Hepatitis
☐Tremor	☐Difficulty feeding	☐ Poor language	☐Easy Bruising	☐Tuberculosis
☐Loss of consciousness	☐Regurgitation	☐ Difficulty walking	☐Easy Bleeding	☐Transfusion

Skin:	Other health conditions :
☐Hives	
☐Eczema	
☐Lesions	
☐Diaper rash	
☐Warts	
☐Scar	

PAST MEDICAL & SOCIAL HISTORY

Day Care	☐Never	☐Occasional	☐Daily
In-House 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

Child 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: ____