Ear, Nose & Throat Consultants- Tongue Tie Medical History Form

Name: ___________________________________ Date: _____/_____/_________
PATIENT DOB:___/___/______ Age: _______ Name of parents / guardians(s):___________________________
Reason for today's visit: ____

Medications: _______________________________________
Allergies to Medications: ___ **None known**
Med _____________________rash/hives/swelling/anaphylaxis/breathing problem
Perinatal / Birth History
Maternal Gestational Diabetes or Pre-eclampsia: ___________________________
Premature/Infection/Jaundice/Intubation/Oxygen/Breathing difficulties? _________________________________
Delivery method (circle one): vaginal/C-section
Born at Gestation week:_______, Birth weight:________, Current weight:_______
Newborn hearing test: Normal/Abnormal/ Not known / Not done/Passed after multiple tests
Feeding history: Feeding time:_____________ Supplementation/pumping?_______________
Lactation consultant:____

____
Previous Surgery (include operations and dates): ____

Patient's Past Medical History:	Yes	No	(please explain if yes)
Ear Infections	O	O	
Number in prior 12 months			___________________
Concerns about hearing	O	O	___________________
Heart Disease/Congenital heart defects	O	O	___________________
Respiratory/lung disease/asthma	O	O	___________________
Digestive/stomach/intestinal disease	O	O	___________________
Urologic/kidney disease	O	O	___________________
Jaundice	O	O	___________________
Other Medical Disease	O	O	___________________

Family Hx Please note which **relatives** have had the following:

	Yes	No	(please explain if yes)
Cancer	O	O	____
Hearing Loss	O	O	____
Environmental Allergies	O	O	____
Bleeding disorders	O	O	____
Headaches	O	O	____
Tongue Tie in family	O	O	____
Other or Unknown	O	O	____

Social Hx
Exposure to cigarette smoke? ____
Any pets at home? ____

Review of Systems
Please indicate whether **your child presently** has any of the following symptoms:

	Yes	No
General/Constitutional		
Weight Loss	O	O
Recover birth weight	O	O
Fevers	O	O
Poor sleep	O	O
Ophthalmologic		
Eye Discharge	O	O
Ears, Nose, Mouth, Throat		
Ear Drainage	O	O
Nasal Congestion	O	O
Mouth Breathing at Night	O	O
Snoring	O	O
Skin		
Skin tags around ears	O	O
Facial birthmarks/lesions	O	O

	Yes	No
Musculoskeletal		
Normal muscle tone	O	O
Respiratory		
Cough	O	O
Wheezing	O	O
Noisy breathing	O	O
Genitourinary		
Difficulty Urinating	O	O
Gastroenterology		
Gassy	O	O
Abnormal bowel movements	O	O
Difficulty swallowing	O	O
Acid reflux	O	O

Reviewed by: _____________________M.D. Date________