Steven Peskind, M.D. & Associates, P.A.

Otitis Media Intake Form

Patient Name: _____ **Date:** _____

Please give your relation to the patient:

Family friend
Family member
Father
Grandparent
Guardian
Mother
Patient
Stepfather
Stepmother

Date of onset of first ear infection: _____

Ear infection status:

Last infection date: _____
Currently infected: ____ Yes _____ No
Number of ear infection in the past 6 months: ____
Total number of ear infections: ____

Timing of ear infections:

Fall
Fall/Winter
Spring
Winter
All year long

Past antibiotic treatment:

Amoxil ____ Number of times used _____
Augmentin ____ Number of times used _____
Biaxin ____ Number of times used _____
Ceftin ____ Number of times used _____
Cefzil ____ Number of times used _____
Clindamycin ____ Number of times used _____
Omnicef ____ Number of times used _____
Rocephin ____ Number of times used _____
Zithromax ____ Number of times used _____
Other: _____ Number of times used _____

Child's social activities:

Church nursery
Mom's day out
Facility based daycare
Play dates
School age sibling(s)
Preschool
In home day care
School

Are there smokers in household? _____ Yes _____ No

Does the patient have cleft palate? _____ Yes _____ No

Are there pets in the home? _____ Yes _____ No

Other symptoms that have been observed:

Sleep disturbances
Speech/hearing issues
Nasal drainage
Decreased hearing
Pulling at ears
Fever
Feeding problems

Select child's speech capabilities:

Babbles appropriately
Approx 50+ words
Approx 50-200 words
Approx 200-500 words
Approx 500-900 words
Approx 900-1500 word
Approx 2000 words

Are child's immunizations current? _____ Yes _____ No

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Patient Name: _____ Date: _____

Whom may we thank for referring you to our office: _____
Please list all other physicians that are treating you at this time: _____
_____

Social History:

Tobacco Use:	Yes	No	How much: _____
Alcohol Use:	Yes	No	How much: _____
Are you pregnant:	Yes	No	

Past Medical History:

Childhood Diseases:

_____ Seizures	_____ Polio	_____ Measles	_____ Rheumatic Fever
_____ Diptheria	_____ Mumps	_____ Scarlet Fever	_____ Whooping Cough

Other: _____

Other Medical Problems:

_____ Migraines	_____ Asthma	_____ Hepatitis	_____ Prostate
_____ Depression	_____ Stroke	_____ Bronchitis	_____ Liver
_____ RSV	_____ Sinusitis	_____ Epilepsy	_____ Emphysema
_____ Ulcers	_____ Ovarian	_____ Oral Problems	_____ Glaucoma
_____ Tuberculosis	_____ Pancreatitis	_____ Arthritis	_____ Thyroid
_____ Cataracts	_____ Mastitis	_____ Diabetes	_____ Premature Birth
_____ Hay Fever	_____ Ear Infections	_____ Intestinal	_____ Breast Disease
_____ Anemia	_____ Angina	_____ Gallstones	_____ Trouble Hearing
_____ Colitis	_____ Phlebitis	_____ Nosebleeds	_____ High Blood Pressure
_____ Heart Murmur	_____ Cough	_____ Clotting	_____ Bladder Infections
_____ Cancer	_____ Heart Disease	_____ Allergies	_____ Kidney Infections

Other: _____

Past Surgery/Hospitalization History:

Have you ever had surgery or been hospitalized? Yes No
If yes, please explain what type of surgery and when or dates of hospital stay and condition:
_____

_____

Family History:

Please list any pertinent family health concerns. Please list the family member and the health condition:
_____

_____

Current Medications and Drug Allergies:

Please list all medications the patient is taking, including prescription, non-prescription and herbal supplements: _____

_____

Please list all known drug allergies: _____

Or circle: No known drug allergies

Patient Name:
_____ **Date:** _____

Constitutional:
Loss of appetite ___ Yes ___ No _____
Fever _____

Respiratory:
Cough ___ Yes ___ No _____
Wheezing ___ Yes ___ No _____

Gastrointestinal:
Diarrhea ___ Yes ___ No _____
Nausea/Vomiting ___ Yes ___ No _____
Jaundice ___ Yes ___ No _____
Reflux ___ Yes ___ No _____

Allergy/Immunology:
Sneezing ___ Yes ___ No _____
Itchy eyes or nose ___ Yes ___ No _____
Hives ___ Yes ___ No _____

Eyes:
Redness ___ Yes ___ No _____
Itching ___ Yes ___ No _____

Ears/Nose/Throat/Mouth:
Hearing loss ___ Yes ___ No _____
Sore throat ___ Yes ___ No _____
Sinus Congestion ___ Yes ___ No _____
Ear pain ___ Yes ___ No _____
Nasal drainage ___ Yes ___ No _____
Ear drainage ___ Yes ___ No _____
Itchy nose ___ Yes ___ No _____
Itchy ears ___ Yes ___ No _____
Itchy throat ___ Yes ___ No _____

Cardiac:
Heart murmur ___ Yes ___ No _____

Neurologic:
Weakness ___ Yes ___ No _____

Skin:
Unusual moles ___ Yes ___ No _____
Rash ___ Yes ___ No _____
Dryness ___ Yes ___ No _____
Itching ___ Yes ___ No _____

Hema/Lymph:
Unusual bleeding/bruising ___ Yes ___ No _____
Swollen nodes ___ Yes ___ No _____