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Country ENT – Paediatric Intake Questionnaire

Patient Details:

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Guardian Name (1): _____

Guardian Name (2): _____

Phone Number: _____

History of presenting Complaint:

Please answer the following questions on the symptoms of concern in your child, and the reason for your consultation.

EAR CONCERNS:

Recurrent Ear Infections / pain / discharge ☐ **Yes** ☐ **No**

If Yes – how many _____

How many this year? _____

How many last year? _____

How many year prior to that? _____

Decreased hearing / Glue Ear ☐ **Yes** ☐ **No**

If Yes – duration in months _____

Speech / Language delay ☐ Yes ☐ No

If yes – had speech pathology? _____

Other / Specify _____

NOSE CONCERNS:

Nasal obstruction / Mouth breathing? ☐ **Yes** ☐ **No**

Runny Nose ☐ **Yes** ☐ **No**

Allergic Symptoms – e.g. Sneezing / Itching / Rubbing nose +/- eyes ☐ **Yes** ☐ **No**

Other / deformity / pain / discharge? Specify: _____

_____

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THROAT CONCERNS:

Snoring / Sleep Disordered breathing ☐ **Yes** ☐ **No**

Enlarged Tonsils / Enlarged Adenoids ☐ **Yes** ☐ **No**

Recurrent Tonsillitis / Throat Infections ☐ **Yes** ☐ **No**

If Yes - Specify: _____

How many in last 12 months _____

How many year prior? _____

How many year prior to that? _____

If Yes - needs antibiotics? ☐ Yes ☐ No

If Yes - any hospital admissions? ☐ Yes ☐ No

If Yes - any complications? e.g. Peritonsillar Abscess, Rheumatic Fever, Febrile convulsion? _____

_____

Dental Crowding / Orthodontic Work? ☐ **Yes** ☐ **No**

Neck lump? ☐ **Yes** ☐ **No**

Other / Specify: _____

Sleep Apnoea Screening Questions:

WHILE SLEEPING, DOES YOUR CHILD:

Snore more than half the time?	☐ Yes	☐ No	☐ Don't Know
Always snore?	☐ Yes	☐ No	☐ Don't Know
Snore loudly?	☐ Yes	☐ No	☐ Don't Know
Have "heavy" or loud breathing?	☐ Yes	☐ No	☐ Don't Know
Have trouble breathing, or struggle to breathe?	☐ Yes	☐ No	☐ Don't Know

Have you ever seen your child stop breathing during the night? ☐ Yes ☐ No ☐ Don't Know

DOES YOUR CHILD:

Tend to breathe through the mouth during the day?	☐ Yes	☐ No	☐ Don't Know
Have a dry mouth on waking up in the morning?	☐ Yes	☐ No	☐ Don't Know
Occasionally wet the bed?	☐ Yes	☐ No	☐ Don't Know

DOES YOUR CHILD:

Wake up feeling unrefreshed in the morning?	☐ Yes	☐ No	☐ Don't Know
Have a problem with sleepiness during the day?	☐ Yes	☐ No	☐ Don't Know

Has a teacher or other supervisor commented that your child appears sleepy during the day? ☐ Yes ☐ No ☐ Don't Know

Is it hard to wake your child up in the morning? ☐ Yes ☐ No ☐ Don't Know

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Does your child wake up with headaches in the morning? ☐ Yes ☐ No ☐ Don't Know

Did your child stop growing at a normal rate at any time since birth? ☐ Yes ☐ No ☐ Don't Know

Is your child overweight? ☐ Yes ☐ No ☐ Don't Know

YOUR CHILD OFTEN:

Does not seem to listen when spoken to directly.	☐ Yes	☐ No	☐ Don't Know
Has difficulty organizing tasks and activities.	☐ Yes	☐ No	☐ Don't Know
Is easily distracted by extraneous stimuli.	☐ Yes	☐ No	☐ Don't Know
Fidgets with hands or feet or squirms in seat.	☐ Yes	☐ No	☐ Don't Know
Is "on the go" or often acts as if "driven by a motor".	☐ Yes	☐ No	☐ Don't Know
Interrupts or intrudes on others (eg., butts into conversations or games).	☐ Yes	☐ No	☐ Don't Know

Total YES _____

Other Medical Problems:

Respiratory Disease – e.g. Asthma, Cystic Fibrosis: ☐ Yes ☐ No

If Yes – Specify: _____

Allergic Disease – e.g. Eczema: ☐ Yes ☐ No

If Yes – Specify: _____

Heart / Cardiac Disease: ☐ Yes ☐ No

If Yes – Specify: _____

Neurological Condition: ☐ Yes ☐ No

If Yes – Specify: _____

Bleeding disorders – e.g Easy bruising, family history of bleeding disorder: ☐ Yes ☐ No

If Yes – Specify: _____

Previous Operations:

Grommets:	☐ Yes	☐ No	If Yes – Year?: _____
Adeno-Tonsillectomy:	☐ Yes	☐ No	If Yes – Year?: _____
Nose surgery:	☐ Yes	☐ No	If Yes – Year?: _____
Other surgery:	☐ Yes	☐ No	If Yes – Year?: _____

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Investigations:

Sleep Study: ☐ **Yes** ☐ **No**

If YES: When? _____ Where? _____ +/- Result? _____

Hearing test?

If YES: When? _____ Where? _____ +/- Result? _____

Meds (Please list):

_____

_____

_____

_____

Allergies to medications (Please list):

_____

_____

_____

_____

Social History:

Term Birth?	☐ Yes	☐ No	**If No** – Specify how many weeks gestation: _____
Newborn Hearing screening?	☐ Yes	☐ No	**If Yes** – passed? _____
Normal developmental milestones?	☐ Yes	☐ No	**If No** – specify: _____
Up to date with vaccinations?	☐ Yes	☐ No	
Child-care / school	☐ Yes	☐ No	
Siblings?	☐ Yes	☐ No	

Any other specific questions/concerns you would like addressed during your consultation?