**Michigan Otolaryngology**
Center for Ear, Nose & Throat Health (ENT)
J. Martin Ulrich, D.O., F.O.C.O.O.

## WELCOME TO OUR OFFICE (Pediatrics - 17 & under)

Patient Name: _____ Date: _____

Did a Physician refer you? ☐ Yes ☐ No If yes, referring Physician name: _____

If referral is other than a Physician, please indicate: ☐ Friend ☐ Family ☐ Phonebook ☐ Internet ☐ Other: _____

List any family members seen by Dr. Ulrich: _____

Reason for today's appointment: _____

How long has this been a problem? _____

What prior treatment has your child received for this problem? _____

_____

Please list: Height _____ Weight _____

Are immunizations up to date? ☐ Yes ☐ No

Does child bruise easily? ☐ Yes ☐ No

Has child ever had a cut in which bleeding was difficult to control? ☐ Yes ☐ No

### PERSONAL MEDICAL HISTORY:

| | | | |
|---|---|---|---|
| ☐ Any Heart Problems | ☐ Hepatitis | ☐ Asthma | ☐ Anemia |
| ☐ Bleeding Disorders | ☐ Hay Fever | ☐ Snoring | ☐ Diabetes |
| ☐ Blood Transfusions | ☐ Convulsions/epilepsy | ☐ Allergies | ☐ Hearing Loss |
| ☐ Restless Sleep | ☐ Headaches | ☐ Sinus Problems | ☐ Other _____ |

### FAMILY HISTORY:

| | | |
|---|---|---|
| ☐ High Blood Pressure | ☐ Lung Disease | ☐ Cancer |
| ☐ Diabetes | ☐ Kidney or Liver Disease | ☐ Stroke |
| ☐ Bleeding Disorders | ☐ Heart Disease | ☐ Hearing Loss |

### SURGICAL HISTORY

Please list any previous surgeries and the year surgery was performed: _____

_____

Do you have any objection to the use of blood products? ☐ Yes ☐ No
*(in the unlikely event they should become necessary)*

Has your child or any family member had a reaction to anly local or general anethetic? ☐ Yes ☐ No

If yes, what type of reaction? _____

_____

### ALLERGIES:

Does your child have any allergies to medications: ☐ Yes ☐ No

If yes, please list: _____

Allergic to Latex? ☐ Yes ☐ No

Allergic to X-Ray Dye? ☐ Yes ☐ No

### MEDICATIONS:

Does your child take any medications on a regular basis? ☐ Yes ☐ No

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| | | | |
| | | | |

PARENT'S SIGNATURE _____ DATE _____ STAFF _____

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