Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

Pediatric Otolaryngology
Vikash K. Modi, MD, FAAP
Alison M. Maresh, MD

Patient Name: _____
Last First Middle Nickname

Mother's Name: _____ Father's Name: _____

Reason for today's visit: _____

Past Medical History: _____

Prior Surgeries: _____

Hospitalizations: YES NO If YES, list reason: _____

Medication Allergies: YES NO If YES, list medications: _____

Current Medications: _____

Birth History:

Passed new born hearing screen?	YES	NO	Medical Problems at birth?	YES	NO
Was your child born full term?	YES	NO	Circle one: Vaginal Delivery	Cesarean Section	
Has your child been on a ventilator?	YES	NO			

Social History:

Anyone smoke in the home?	YES	NO	Is your child in daycare or school?	YES	NO

Family Illnesses: _____

REVIEW OF SYSTEMS

Fever	YES	NO	**Eyes:**	Vision problems	YES	NO
Issues with Weight/nutrition/feeding	YES	NO	**Cardiovascular:**	Heart problems	YES	NO
Genetic Disorder	YES	NO	**Musculoskeletal:**	Developmental abnormalities?	YES	NO

Ear, Nose and Throat:

Concern with possible hearing loss	YES	NO	Difficulty sleeping at night	YES	NO
Speech development issues/delay	YES	NO	Snoring (if yes, answer below)	YES	NO
Balance disturbance	YES	NO	Loud and obstructive	YES	NO
Nosebleeds	YES	NO	Noisy breathing/stridor	YES	NO
Nasal congestion/Mouth breathing	YES	NO	Working to breathe	YES	NO
Liquids come out of nose when drinking	YES	NO	Daytime tiredness	YES	NO

Number of ear infections ____ Tonsil infections ____ Sinus infections ____ in the past six months.
Number of ear infections ____ Tonsil infections ____ Sinus infections ____ in the past twelve months.

Pulmonary:

Asthma	YES	NO
Cough	YES	NO
Bronchitis/Pneumonia	YES	NO

Allergy/Immunology:

Environmental/Food allergy	YES	NO
Immunologic disorder	YES	NO
Previous allergy testing	YES	NO

Neurologic

Developmental delay	YES	NO
Hypotonia	YES	NO
Hyperactivity	YES	NO

Endocrine: Thyroid Abnormalities YES NO

Gastrointestinal:

Gastroesophageal Reflux	YES	NO
Recurrent spitting up /vomiting	YES	NO

Hematology:

Easy bruising/bleeding	YES	NO
Family history of bleeding problems	YES	NO

Genitourinary: Does your child bedwet? YES NO

Integumentary: Any skin abnormalities YES NO

Psychiatric: Psychiatric conditions YES NO

The above information is accurate to the best of my knowledge.

X _____

Signature of Parent or Guardian | Print Name of Parent or Guardian | Relationship to Patient | Date

FOR PHYSICIAN'S USE ONLY:

I have reviewed the above information with the patient.

_____ _____

Physician Signature | Date

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Referring Physician, Medication, and Pharmacy Information Form

Patient's Name: _____ Date: _____

The name and address of the Primary Care Physician OR Referring Doctor:

Physician's Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Are there any allergies to Medications? NO Yes (please list): _____

Please list all current medications, including over-the-counter medications such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, etc.)

Medication	Dosage (mg, teaspoons, etc)	Frequency

Pharmacy Information:

Pharmacy Name: _____

Address: _____

_____

Telephone: _____

∗Date of most recent Flu Shot (ages 6 months +)_____**∗Date of most recent Pneumonia shot (ages 65+)**_____

The above information is accurate to the best of my knowledge.

X

Signature of Patient or Guardian | Print Name of Patient or Guardian | Relationship to Patient | Date

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PAYMENT POLICY FOR PEDIATRIC IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

Cerumen removal: **Removal of wax from the ear canals**

Frenulectomy: Procedure performed to correct tongue-tie (ankyloglossia).

Nasal Endoscopy/Nasopharyngoscopy: Examination nasal cavity/sinuses and adenoids with a fiberoptic scope

Nasal endoscopy with control of epistaxis: Examination of the nasal cavity with a fiberoptic scope followed by cauterization for nosebleed.

Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.

Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name (Print) _____

Signature _____ Date _____
(Patient or Responsible Party)