Riley Hospital for Children
Indiana University Health

Patient Medical History Form

Pre-Surgical Bleeding History Questionnaire

Name: _____

CIRCLE the appropriate response: "Y" yes or "N" no.

A. Patient History

1. Has the patient ever had surgery, stitches for trauma or a broken bone? Y N
   If YES, did the patient experience bleeding during or after the procedure? _____
   What was the procedure? _____
2. Does the patient bruise easily compared to normal? Y N
3. If the patient is a boy, did he bleed after circumcision? Y N
4. Did the patient bleed after the umbilical cord came off? Y N
5. Has the patient had frequent nosebleeds? Y N
6. Has the patient bled after tooth extractions, wisdom tooth surgery or with the loss of baby teeth? Y N
7. Is the patient taking any of the following:
   - A. Aspirin Y N
   - B. Ibuprofen products Y N
   - C. Antihistamines Y N
   - D. Herbs, alternative, traditional or homeopathic supplements Y N

   If YES, which ones? _____
8. Is there any history of heavy menstrual periods? Y N

B. Family History

1. Are there women in your family (mother, aunt, sister, grandmother) who have had heavy monthly periods requiring either iron therapy or transfusions? Y N
2. Is there anyone in the family with a history of frequent nosebleeds judged to be severe or requiring a blood transfusion? Y N
3. Is there anyone in your family who bled after tooth extractions, wisdom tooth surgery or loss of baby teeth? Y N
4. Has anyone in your family required a blood transfusion? Y N
   Who? _____ Reason for transfusion? _____
5. Has anyone in the family been called a free bleeder? Y N
6. Has anyone in your family ever bled after tonsil surgery, childbirth or other operations? Y N
7. Is there anyone in the family with hemophilia, Von Willebrand disease, low platelets or ITP? Y N
   Who? _____ Diagnosis? _____

Patient Name: _____ Date of Birth: _____ Sex: M F
Primary Care Physician: _____ Referring Physician: _____

Patient Chief Complaint

Reason for today's visit? _____
Have you seen another doctor for this problem? Yes No Who? _____
If so, did that doctor do any tests, X-rays, etc. for this problem? Yes No Tests _____
Has the patient been seen by any of our doctors before? Yes No
Have any family members of the patient been seen by any of our doctors before? Yes No
If so, what are the names of the family members? _____

Patient Medical History

Birth History

How many weeks into pregnancy was child born (gestational age)? _____
Birth weight? _____ pounds _____ ounces (or) _____ gm _____ Vaginal delivery? _____ Cesarean section? _____
Any infections in mother during or after pregnancy or in child at birth? _____
Any medications used by mother during pregnancy or while nursing? _____
Any recreational drug use by mother during pregnancy or while nursing? _____
Did child need ICU after delivery? _____
Did child need a ventilator-breathing machine after delivery? _____
Did child need IV medications/antibiotics/other therapies in the neonatal period?
_____
Did child need jaundice treatment in the neonatal period? _____
Please list any prior major illnesses and/or injuries: _____
_____
_____

Patient's Surgeries/Hospitalizations	Year	Complications

Has the patient ever had problems with anesthesia? Yes No If so, what were they? When? _____
_____
Does the patient have any drug allergies? Yes No If so, what are they and what is the reaction?
_____
Are the patient's immunizations up to date? Yes No

Current Medications/Supplements/Herbals*	Strength	Dose	Frequency

*Include any medication for weight loss (prescription or over-the-counter), food supplements and herbs.

Family History

Does the patient have any blood relatives with:

Cancer	Yes	No	Who? _____
Heart disease	Yes	No	Who? _____
Stroke	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____

History of hearing loss/deafness at young age? Yes No Who? _____
History of life-threatening anesthetic reactions at surgery? Yes No Who? _____

Social History

Does the child attend day care? Yes No
Does the child attend school? Yes No Public Private Home Other
Do people at home smoke? (Inside or outside the house.) Yes No
Does the patient use tobacco, alcohol or recreational drugs? Yes No

Review of Systems

Does the patient currently, or has the patient ever had, problems with:

General Health

Height: _____ Weight: _____
Fever Yes No
Weight loss Yes No
Excessive fatigue Yes No
Night sweats Yes No
Other: _____
What doctor do you see for primary care? _____

Eyes & Vision

Wear glasses Yes No
Vision loss Yes No
Glaucoma Yes No
Other: _____
What doctor do you see for eye care? _____

Ears, Nose, Throat and Mouth

Wear hearing aids Yes No
Hearing loss Yes No
Ear pain Yes No
Ear infections Yes No
Ringing in ears Yes No (Please circle one) Left Right
Balance disturbance (e.g., vertigo or spinning) Yes No
Nosebleeds Yes No
Nasal congestion Yes No
Nasal drainage Yes No
Change in taste/smell Yes No
Sinus problems Yes No
Sinus headaches Yes No
Sore throats Yes No
Mouth sores Yes No
Hoarseness Yes No
Snoring Yes No
Other: _____
What doctor do you see for ear, nose and throat care? _____

Cardiovascular

Chest pain or angina Yes No
High blood pressure Yes No
Heart murmur Yes No
Mitral valve prolapse Yes No
Congenital heart disease Yes No
Other: _____

What doctor do you see for cardiac care? _____

Respiratory

Asthma	Yes	No
Chronic cough	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No

Other: _____

What doctor do you see for pulmonary care? _____

Digestive

Difficulty swallowing	Yes	No
Heartburn/ulcer/reflux	Yes	No
Liver disease/hepatitis	Yes	No

Other: _____

What doctor do you see for digestive care? _____

Genitourinary/Kidney/Bladder

Kidney/bladder problems	Yes	No
Bedwetting	Yes	No

Other: _____

What doctor do you see for urologic care? _____

Musculoskeletal

Broken bones	Yes	No
Arthritis	Yes	No
Scoliosis	Yes	No

Other: _____

What doctor do you see for musculoskeletal care? _____

Skin

Skin cancer	Yes	No	
Eczema	Yes	No	
Birthmarks	Yes	No	If yes, what part of body? _____

Other: _____

What doctor do you see for dermatology care? _____

Neurological/Psychiatric

Stroke	Yes	No
Fainting spells or "blacking out"	Yes	No
Seizures	Yes	No
Disorientation	Yes	No
Mental health	Yes	No
Attention deficit/hyperactivity	Yes	No

Other: _____

What doctor do you see for neurological care? _____

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No
Kidney disease	Yes	No

Other: _____

What doctor do you see for endocrinology care? _____

Hematologic/Lymphatic

Bleeding problems	Yes	No
Anemia	Yes	No

Sickle cell anemia Yes No
Other: _____
What doctor do you see for hematology care? _____

Allergic/Immunologic

Food allergies Yes No
Drug allergies (list on page 2) Yes No
Inhalant (nasal) allergies Yes No
Latex allergies Yes No
Immunologic disorders Yes No
Other: _____
What doctor do you see for allergies/immunology care? _____

****

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

_____

Parent/Legal Guardian Date

As the physician, I have reviewed the above information with the patient.

_____

Otolaryngologist's Signature Date

FOR OFFICE USE ONLY