MEDICAL REVIEW FORM Page 1

Name of Patient: .....

What is your child's weight?	
Has your child had any problems with their health apart from the issues that have lead to this appointment?	Please specify:
Have they had any previous operations?	Please specify:
Does your child or anyone else in the extended family have any history of - excessive bleeding or easy bruising? - adverse reaction to local or general anaesthetic agents?	Yes / No Yes / No
Do you have any religious beliefs that prevent your child from receiving blood products?	Yes / No
Are they on any regular medications? (include any over-the-counter or herbal medications)	Please specify:
Any allergies to medications? Any other allergies? (eg. Band-Aids, foods, animals)	Please specify:
Has your child had immunizations? If yes, are they up to date?	Yes / No Yes / No
Does your child attend Day Care / Child Care, Kindergarten, or School?	Please specify (including year level at school if applicable):

PLEASE PROCEED TO PAGE 2 OF THE MEDICAL REVIEW FORM

MEDICAL REVIEW FORM Page 2

Has your child had any ear infections requiring antibiotics?	Yes / No
If so, how many ear infections have there been in the last six months?	..... ear infections
Has your child been diagnosed with “fluid behind the ears” or “glue ear”?	Yes / No
If so, how long do you think that this has been present?	..... months
Are there any concerns with your child’s hearing?	Yes / No
Did they pass the screening test of hearing at birth?	Yes / No
Has your child ever had a subsequent hearing test?	Yes / No
If so, was their hearing normal on this test?	Yes / No
Are there any concerns with your child’s speech development?	Yes / No
If yes, please specify:	
Does your child have any difficulties breathing through their nose?	Yes / No
Are they troubled by a persistently snotty nose?	Yes / No
Do they have symptoms of hay fever (itchy eyes, itchy nose, sneezing)?	Yes / No
Does your child snore?	Yes / No
Do they make snorting sounds when asleep?	Yes / No
Are they restless when asleep?	Yes / No
Are they sweaty when asleep?	Yes / No
Has your child had any episodes of tonsillitis requiring antibiotics?	Yes / No
If so, how many tonsil infections have there been in the last twelve months?	..... tonsil infections

THANK YOU FOR COMPLETING THIS FORM