INTAKE FORM - ADENOIDS

Name: _____ DOB (dd/mm/yyyy): _____

What tonsil issues prompted your child's referral to Dr. Mabini? (please circle):

Recurrent infections (colds, strep throat) Sleep apnea Snoring Enlarged adenoids

Other: _____

Does your child have, or have they previously had any of the following symptoms? (please check if yes):

- ☐ Recurrent throat infections
- ☐ Frequent sore throat
- ☐ Irritability
- ☐ Fatigue
- ☐ Snoring
- ☐ Voice hoarseness
- ☐ Sleep apnea
- ☐ Difficulty concentrating
- ☐ Poor school performance
- ☐ Ear infections
- ☐ Trouble swallowing
- ☐ Trouble breathing or "mouth breathing"

Have they had an adenoid x-ray? When?: _____

Have they ever had a sleep study? If yes, when? What were the results?:

_____

Does your child have environmental allergies? Have they ever been allergy tested?

_____

Does your child use a nasal steroid spray or do saline nasal rinses? _____

What other treatments have they tried, if any? _____