ENT Ear, Nose & Throat Specialty Care

Pediatric Medical History Form

Today's Date:_____/_____/_____

PATIENT NAME: ____ **DATE OF BIRTH**:_____/______/_______

(First Name) (MI) (Last Name)

Gender: ☐ **Male** ☐ **Female** ☐ **Other:**_____________ **Primary #:** ____________________ **Email:**_________________________

Home Address: ____**City:**____________________**State:**_______**Zip Code:**_________

Responsible Party Name: ____ **Date Of Birth:**______/_______/________

Insurance Name/Policy#:______________________________ **Policy Holder Name/Date of Birth:**_______________________________

Name of primary physician:______________________________**Name of referring physician:** __________________________________

Pharmacy Name and City: ____ **Phone #:**___________________

Emergency Contact: ___________________________________ **Relationship:** ___________________ **Phone #:**___________________

I. Reason for visit: ____

II. Medication History

Prescription drugs your child takes now: ☐ None

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Over the counter medications your child takes now: ☐ None ☐ Aspirin ☐ Ibuprofen ☐ Tylenol

☐ Nasal Spray, Name: ________________________________ ☐ Allergy medication, Name: ___________________________________

☐ Antacid medication: _________________________________ ☐ Other: ____

III. Medical History: ☐ None

☐ Congenial heart disease ☐ Easy bleeding or bruising problems ☐ Prematurity ☐ Anxiety

☐ Anesthesia problems ☐ Asthma ☐ Sleep apnea

☐ Reflux or easy vomiting ☐ Did not pass newborn hearing screen ☐ Depression

☐ Diagnosed syndrome: ____

☐ Other medical concerns: ____

IV: Allergies:

i. Does your child have any allergies to drugs or medications: ☐ Yes ☐ No

If yes, list medication and reaction:____

ii: Does your child have any environmental, food or latex allergies: ☐ Yes ☐ No

If yes, list allergy and reaction: ____

V. Surgical History: Has your child ever had surgery? ☐ Yes ☐ No

If yes, list:

____ Date: ________________________

____ Date: ________________________

VI. Family History: Does anyone in your family have/had any of the listed problems? ☐ None ☐ Family History Unknown

☐ Anesthesia problems Who:____________________

☐ Easy bleeding or bruising problems Who:____________________

☐ History of frequent ear infections Who:____________________

☐ Hearing loss Who:____________________

☐ Environmental Allergies Who:____________________

VII: Social History:

1. **Parental Tobacco Use and Smoking:**
   Do the parents or primary caregivers smoke? ☐Yes ☐No
   Who smokes? ☐Mother ☐Father ☐Other
   Is tobacco used inside or outside the home? ☐ Inside ☐Outside ☐Both
   Is tobacco used around the child? ☐ Yes ☐ No

2. **Is the child in daycare?**
   ☐ Yes ☐ No

3. **Are there pets with hair or dander at home?**
   ☐ Yes ☐ No

   If yes, list: ____________________

VIII: Review of Symptoms: Check box for problems you have now.

Ear Nose Throat (ENT)
☐ Ear pain
☐ Hearing loss
☐ Snoring
☐ Mouth breathing
☐ Nasal congestion
☐ Sore throat
☐ Hoarseness
☐ Lump in neck
☐ Weak cry

Lungs
☐ Shortness of breath
☐ Wheezing
☐ Noisy breathing

Constitutional
☐ Fever
☐ Fatigue

Endocrine
☐ Diabetes

Digestive
☐ Swallowing problems
☐ Choking

Heart
☐ Murmur
☐ Congenital heart disease

Neurologic
☐ Seizures
☐ Weakness
☐ Developmental delay

Skin
☐ Hives
☐ Itching

Eyes
☐ Blindness
☐ Double vision
☐ Eye pain

Blood
☐ Anemia
☐ Bleeding or bruising easily

Genitourinary
☐ Kidney problems

Print Name:____________________ Signature:____________________ Date:____________________