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:**_____ **Phone #(required):** _____ **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: _____

## CONSENT TO COMMUNITCATE

**I authorize Ear, Nose & Throat Specialty Care to communicate with the following person(s) regarding my medical care and information:**

| Name | Relationship | Phone Number | Scheduling | | Medical | | Billing | |
|---|---|---|---|---|---|---|---|---|
| | | | Y | N | Y | N | Y | N |
| | | | Y | N | Y | N | Y | N |
| | | | Y | N | Y | N | Y | N |

**The above Consent to Communicate authorization will expire 36 months from the date signed unless an earlier date is provided here:_____.**

Print Name:_____ Signature:_____Date:_____