SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

CHILD

Patient's Name: _____ *D.O.B.* _____

Referring Physician: _____

Name and Location of Pharmacy Used: _____

What is the doctor seeing your child for today? _____

List all current medication including any over the counter (OTC) medications or supplements that your child is 'taking.

❑ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines your child can not take

❑ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Does your child have known allergy to any of the following? ❑ **NONE**

❑ **Latex** ❑ **Iodine** ❑ **Tape** ❑ **Contrast Agents (Dye)** ❑ **Other** _____
Please Describe

❑ **Describe reaction** _____

Allergies

- ❑ **None**
- ❑ **Dust**
- ❑ **Moldy Places**
- ❑ **Pollen**
- ❑ **Cut Grass**
- ❑ **Animals**
- ❑ **Exercise**
- ❑ **Foods**
- ❑ **Smoke/Fumes**
- ❑ **Outside In Spring and/or Fall**
- ❑ **Outside on Windy Days**
- ❑ **Air Conditioning**

Allergy Testing

- ❑ **Never Done**
- ❑ **Skin Blood**
- ❑ **Negative**
- ❑ **Where Testing Done**

Allergy Injections

- ❑ **Never Done**
- ❑ **In the Past**
- ❑ **Currently**

Other Allergies/Problems Not Listed

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

_____

_____

Past Health History

Please Indicate any diseases or problems that your child has had or been diagnosed with by a doctor

❑ No Major Illnesses

1. Congenital (Birth) Problems
   - ❑ Down's Syndrome
   - ❑ Heart Defect
   - ❑ Prematurity (# of weeks _)
   - ❑ Other_____

2. Childhood Diseases
   - ❑ Mumps
   - ❑ Measles
   - ❑ Chicken Pox
   - ❑ Other_____

3. Cancer
   - ❑ Lung Cancer
   - ❑ Breast Cancer
   - ❑ Throat Cancer
   - ❑ Leukemia
   - ❑ Other_____

4. Head & Face (not incl. brain or nervous s stem)
   - ❑ Tension/Stress Headache
   - ❑ Other_____

5. Ears
   - ❑ Chronic or Frequent Infection
   - ❑ Fluid
   - ❑ Hearing Loss
   - ❑ Vertigo
   - ❑ Other_____

6. Nose and Sinuses
   - ❑ Chronic Sinusitis
   - ❑ Deviated Septum
   - ❑ Nasal Polyps
   - ❑ Allergies
   - ❑ Other_____

7. Mouth and Throat
   - ❑ Chronic Tonsillitis
   - ❑ Cleft Palate
   - ❑ Sleep Apnea
   - ❑ Vocal Polyps
   - ❑ Other_____

8. Heart
   - ❑ Atrial Fibrillation
   - ❑ Chest Pain / Angina
   - ❑ Heart Attack
   - ❑ High Blood Pressure
   - ❑ Mitral Valve Prolapse
   - ❑ Heart Murmur
   - ❑ Pace Maker
   - ❑ Other_____

9. Lungs
   - ❑ Asthma
   - ❑ COPD/Emphysema
   - ❑ Cystic Fibrosis
   - ❑ On Oxygen
   - ❑ Other_____

10. Digestive
   - ❑ GERD/Reflux
   - ❑ Hepatitis
   - ❑ Diverticulitis
   - ❑ Hemorrhoids
   - ❑ Other_____

11. Skin
   - ❑ Eczema
   - ❑ Psoriasis
   - ❑ Acne
   - ❑ Other_____

12. Neurologic
   - ❑ Headaches
   - ❑ Stroke
   - ❑ Multiple Sclerosis
   - ❑ Other_____

13. Glands and Hormones
   - ❑ Diabetes
   - ❑ Thyroid Problem
   - ❑ Other_____

14. Blood Disorder
   - ❑ Low White Blood Cells
   - ❑ Bleeding Disorder
   - ❑ Anemia
   - ❑ Low Platelets
   - ❑ Other_____

15. Immune Disorder
   - ❑ Rheumatoid Arthritis
   - ❑ Sjogrens
   - ❑ CREST
   - ❑ HIV
   - ❑ Other_____

16. Psychiatric History
   - ❑ Depression
   - ❑ Anxiety
   - ❑ Mania
   - ❑ Schizophrenia
   - ❑ Other_____

Surgeries / Injury

Has your child ever had problems with anesthesia (being put to sleep for surgery)? ❑ Yes ❑ No

Please list any surgeries your child has had

❑ No Surgery

Name of Operation: Date:

_____

_____

Please list any admissions to a hospital other than the above.

❑ No Hospitalization

Reason for hospitalization: Date:

_____

_____

Family History ❑ Family History Unkown

Do any of your child's BLOOD RELATIVES have a history of:

- ❑ Problems with Anesthesia, malignant hypothermia
- ❑ Hearing Loss after age 20
- ❑ Hearing Loss before age 20
- ❑ Heart Problems
- ❑ Bleeding / Clotting Problems
- ❑ Cancer
- ❑ Other Major Health Problems

_____
Please Describe

- ❑ No family history problems known

Social History

Marital status of parents: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Is child adopted?: ❑ Yes ❑ No

Names of child's parents:

_____

_____

Names of child's siblings: _____

_____ _____

_____ _____

Review of Systems / Symptoms

Please indicate any other symptoms that you have now or have had in the RECENT past.

General
- ❑ None
- ❑ Fever
- ❑ Sleeping Problems
- ❑ Unintentional Weight Loss

Allergy Symptoms
- ❑ None
- ❑ Dust
- ❑ Moldy Places
- ❑ Pollen
- ❑ Cut Grass
- ❑ Animals
- ❑ Exercise
- ❑ Foods
- ❑ Smoke/Fumes
- ❑ Outside in Spring and/or Fall
- ❑ Outside on Windy Days
- ❑ Air Conditioning

Allergy Testing
- ❑ Never Done
- ❑ Skin Blood
- ❑ Negative
- ❑ Where Testing Done

_____

Allergy Injections
- ❑ Never Done
- ❑ In the Past
- ❑ Currently

Other Allergies/Problems Not Listed
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

_____

_____

_____

_____
Please Describe

Facial / Eye Problems
- ❑ None
- ❑ Headaches
- ❑ Facial Pain
- ❑ Facial Weakness
- ❑ Vision Changes Not Corrected by Glasses
- ❑ Other Facial or Eye Problems:

_____
Please Describe

Ear Problems
- ❑ None
- ❑ Ear Pain
- ❑ Ear Drainage
- ❑ Hearing Loss
- ❑ Dizziness
- ❑ Ringing in Ears (Tinnitus)
- ❑ Other Ear Problems:
- ❑ Infection
- ❑ Pressure

_____
Please Describe

Nose Problems
- ❑ None
- ❑ Nasal Obstruction
- ❑ Nasal Congestion
- ❑ Bleeding from Nose
- ❑ Sinus Drainage
- ❑ Other Nose Problems:

_____
Please Describe

Mouth Problems
- ❑ None
- ❑ Voice Change / Hoarseness
- ❑ Loud Snoring
- ❑ Sore Throat
- ❑ Trouble Swallowing
- ❑ Other Mouth Problems:

_____
Please Describe

Neck Problems
- ❑ None
- ❑ Neck Mass
- ❑ Other Neck Problems:

_____
Please Describe

Heart Problems
- ❑ None
- ❑ Chest Pain
- ❑ Lightheadedness
- ❑ Other Heart Problems:

_____
Please Describe

_____
Cardiologist

Lung Problems
- ❑ None
- ❑ Frequent Cough
- ❑ Difficulty Breathing
- ❑ Other Lung Problems:

_____
Please Describe

Stomach / GI Problems
- ❑ None
- ❑ Abdominal Pain
- ❑ Heart Burn / Indigestion
- ❑ Other Stomach / GI Problems:

_____
Please Describe

Urinary or Female Health Problems
- ❑ None
- ❑ _____

Please Describe

Bone / Muscle Problems
- ❑ None
- ❑ Painful Joints
- ❑ Other Bone / Muscle Problems:

_____
Please Describe

Breast or Skin Problems
- ❑ None
- ❑ _____

Please Describe

Brain or Nerve Problems
- ❑ None
- ❑ Change in Smell
- ❑ Change in Taste
- ❑ Numbness
- ❑ Weakness
- ❑ Other Brain or Nerve Problems:

_____
Please Describe

Blood or Lymph Problems
- ❑ None
- ❑ Excessive Bleeding
- ❑ Other Blood or Lymph Problems:

_____
Please Describe

Immune Problems
- ❑ None
- ❑ Unusual Infections
- ❑ Other Immune Problems:

_____
Please Describe

Other Medical Problems Not Listed
- ❑ _____
- ❑ _____
- ❑ _____

_____

_____

_____
Please Describe