Welcome to Children's ENT of Houston!

In order to provide you with the best possible care please fill out both pages of this medical history form. All information is completely confidential.

Patient Medical History Form: Child

Drug/Latex Allergies: ________________
____
(if none, please write "none")
If yes, what type of reaction: __________
____

Today's Date: ___________________

Patient Name: __________________________________
Date of Birth: _________________ Age: _____________
Weight: ________________ Male_______ Female _______
Pediatrician or Family Doctor: ____
Physician who referred you today: ____

History of Present Illness

What is the reason for your child's visit today? ____
____
How long has your child had this problem? ____
What other physician has treated your child for this problem? _____________________________________
Has your child been evaluated by any of the following?
□ Allergist □ Pulmonologist □ Speech Pathologist □ Orthodontist/Dentist □ Gastroenterologist

Past Medical History

Birth history: □ Full-term □ Pre-term ______________ # of weeks
□ Single □ Twins (Fraternal ____or Identical ____) □ Multiple #______

Does your child no have or has he/she ever had any of the following?

□ ADHD	□ Diabetes	□ Irregular heartbeat
□ AIDS/HIV positive	□ Down Syndrome	□ Kidney problems
□ Allergies	□ Ear infections	□ Lung disease
□ Anemia	□ Epilepsy/seizures	□ Psychiatric disease
□ Asthma	□ Hearing problems	□ Reflux disease
□ Blood disease	□ Heart failure	□ Sickle cell disease
□ Blood transfusion	□ Hemophilia	□ Sinus infections
□ Cancer	□ Hepatitis A	□ Strep Throat
□ Congenital heart disease	□ Hepatitis B or C	□ Tuberculosis
□ Cystic Fibrosis	□ Hospitalized at birth	

Please list any other serious illness not listed above: ____

Past Hospitalization or Emergency Room Visits

Please list the date(s) and reason for any hospitalizations or emergency room visits: ________________
____

Past Surgical History

Please list the type(s) and date(s) of all surgical procedures your child has had: _____________________
____
____

Medications

Please list all medications your child takes regularly, including over the counter and herbal medicines:

____

____

Any aspirin or ibuprofen use? □ YES □ NO How often? ___________________________________

Review of Systems

Does your child now have or has he/she ever had any of the following?

□ Abdominal pain
□ Abnormal bleeding
□ Anesthesia difficulties
□ Blood in stool
□ Breathing problems during sleep
□ Bruise easily
□ Chest pain
□ Convulsions/seizures
□ Cough
□ Dizziness
□ Ear fluid or infections
□ Frequent headache
□ Frequent spitting up
□ Hay fever
□ Headaches
□ Hearing loss
□ Hoarseness
□ Joint swelling
□ Limb swelling
□ Malignant hyperthermia
□ Mouth breathing
□ Noisy breathing
□ Sinus disease
□ Skin lesions/swellings
□ Snoring
□ Sore throat/strep throat
□ Speech/Language difficulties
□ Tonsil problems

Family Medical History

Do any of your family members (living or dead) have any history of the following:

□ AIDS
□ Allergies
□ Anesthesia problems
□ Asthma
□ Blood disease
□ Cancer
□ Cystic Fibrosis
□ Diabetes
□ Dizziness
□ Ear fluid or infections
□ Excessive bleeding
□ Epilepsy/seizures
□ Headaches
□ Hearing loss
□ Hemophilia
□ High blood pressure
□ Kidney problems
□ Sickle cell disease
□ Sinus disease
□ Sleep apnea
□ Stroke
□ Thyroid disease
□ Tonsil problems
□ Tuberculosis

Please list any other serious illness not listed above: ____

Social History

Is your child in daycare? □ YES □ NO

Is your child in school? □ YES □ NO If in school, what grade? ____________________

Does your child use a pacifier? □ YES □ NO

Does anyone in your household smoke? □ YES □ NO

Please list siblings and ages: ____

Please list siblings previously seen by physicians at our practice and the reason(s) for visit or treatment:

____

The information provided is a complete and accurate reporting of my child's medical history and health status.

Parent/Guardian signature: ____ Date: ____________________

Reviewed by physician: _______________________________________MD Date: ____________________