ENT & Audiology Center of Southlake

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Patient Name:_____ DOB: _____ Today's Date: _____

PCP _____ Referring Provider _____ Not Referred _____

Your relationship to the patient: Parent ____ Legal Guardian ____ Other_____

Current Medical Concern(s)

What is the reason for today's visit/current medical concerns?

_____

_____

How long has this problem existed? _____

Have you consulted any other providers about this problem? Yes / No

If yes, please give name of provider and date of consultation(s).

_____

_____

Current Living/Household Status

Does anyone in the household smoke? Yes / No

Does your child attend school? Yes / No If yes, what grade_____

Does your child attend daycare? Yes / No If yes, how many days/wk _____

Any pets in the home? Yes / No List: _____

List all people who live with the patient: _____

_____

Birth History

Name and City of Birth Hospital _____

Did your child pass their newborn hearing screening test? ____Yes ____No ____Unknown

___ Full Term ___ Premature How many weeks premature? _____

Did your child ever stay in the NICU? Yes / No If yes, how long? _____

Has your child ever required a breathing tube? Yes / No If yes, how long? _____

Any other significant birth history info: _____

Medication History

Does your child have any medication allergies? Yes / No:

If yes, list medication (s) and date and type of reaction: _____

_____

_____

Currently taking any medications? Yes / No

If yes, what medications? Include over the counter and all prescriptions:

Pharmacy_____ Location_____ Phone#_____

Patient Name: _____ Date: _____

Past Medical History

Does your child have, or ever had, any of the following?

Allergies	Yes / No	Diagnosed by Allergist	Yes / No
Asthma or breathing problems	Yes / No	Anesthesia Difficulties	Yes / No
Bleeding Disorders	Yes / No	Cancer	Yes / No
Diabetes or Endocrine Problems	Yes / No	Gastrointestinal Disorders	Yes / No
Hearing Problems	Yes / No	Heart Problems	Yes / No
Immunization Up to Date	Yes / No	Seizure Disorder	Yes/ No
Neurological Disorder	Yes / No	Syndrome	Yes / No
Other	Yes / No		

Please describe all Yes answers, and explain if immunizations are not up to date:

_____
_____
_____
_____
_____

Past Surgical History

Please list all surgical procedures your child has had. If none, state "None."

Procedure	Date	Surgeon/Location

Family History

Does any direct relative in the child's family have a history of any of the following?

Anesthesia Difficulties	Yes / No	Bleeding Disorders	Yes / No
Ear Surgery	Yes / No	Head or Neck Cancer	Yes / No
Hearing Loss	Yes / No	Other	Yes / No

If you answered yes, what is family relationship to your child and what is the history?

_____
_____

Name of Person Completing Form_____ Signature_____