NORTHERN VALLEY **ENT**

Pediatric Intake Form

Patient's Name _____ Age _____

Reason for Today's Visit _____

Medications

List Present Medications & Dosage 1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

Has your child taken any of the following:

☐ Penicillin	☐ Amoxicillin	☐ Augmentin	☐ Erythromycin	☐ Biaxin	☐ Zithromax
☐ Bactrim/Septra	☐ Sulfa	☐ Pediazole	☐ Gantrisin	☐ Ceclor	☐ Cefzil
☐ Lorabid	☐ Ceftin	☐ Cedax	☐ Suprax	☐ Vantin	

List any prior hospitalizations/operations with dates: _____

_____

_____

List any serious illnesses or injuries with dates: _____

_____

_____

Does the child have or had in the past:

☐ Asthma	☐ Cough	☐ Snoring	☐ Mouth Breathing
☐ Restless Sleep	☐ Nasal Discharge	☐ Sore Throat	☐ Strep Infections
☐ Tonsillitis	☐ Bad Breath	☐ Scarlet Fever	☐ Hearing Loss
☐ Ear Infections	☐ Ear Discharge	☐ Hoarseness	☐ Difficulty Swallowing
☐ Thyroid Problems	☐ Seizures	☐ Eye Problems	☐ Diabetes
☐ Mononucleosis	☐ Croup	☐ Heart Problems	☐ Head Injury
☐ Bronchitis	☐ RSV	☐ Lyme Disease	☐ Headaches

Does anyone in the family smoke? ☐ Yes ☐ No Does your child smoke? ☐ Yes ☐ No

Has/is the child seeing an allergist? ☐ Yes ☐ No Received/receiving shots? ☐ Yes ☐ No

Does the child or anyone in the family have a bleeding problem (easy bruising, slow blood clotting)? ☐ Yes ☐ No

Has anyone in the family had an unfavorable reaction to anesthesia? ☐ Yes ☐ No If yes, please explain: _____

_____

Is there a family history of hearing loss? ☐ Yes ☐ No

Family History (check any that apply)

☐ Asthma	☐ Diabetes	☐ Tuberculosis	☐ High Blood Pressure
☐ Stroke	☐ Autoimmune Disease	☐ Heart Disease	☐ Headaches
☐ Allergies	☐ Cancer	☐ Thyroid Disease	☐

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No If yes, please explain: _____

_____

Was the child kept in the hospital more then 48 hrs. after birth? ☐ Yes ☐ No If yes, please explain: _____

_____

Is there anything else about the child's medical history that might be helpful for the doctor to know? _____

_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

Parent/Guardian Signature _____ Date _____