PENTA

Pediatric Ear, Nose & Throat of Atlanta, P.C.

MEDICAL HISTORY FORM

404.255.2033

Putting Your Child First

Name ________________ ________________ ________________ Date ______–______–________

First Middle Last

Age ________ DOB ______–______–________ Weight ________ lbs.

Allergies to medications: ☐ Y ☐ N Allergies to foods: ☐ Y ☐ N

If yes, please list: ____

Current Medications: ____

Child's Medical History:

☐ Y ☐ N Was your child born full term? At how many weeks? ________ Birth Weight ________ lbs.

☐ Y ☐ N Was your child able to go home from the hospital with you? If not, why? ________________

☐ Y ☐ N Has your child ever received a blood transfusion?

☐ Y ☐ N Is there a family history of bleeding problems?

☐ Y ☐ N Does your child have a history of bleeding problems?

☐ Y ☐ N Is there a family history of anesthesia problems? If yes, please explain: ________________

☐ Y ☐ N Are there other family history issues? (e.g., hearing loss, sleep apnea, cancer, etc.)

If yes, please explain: ____

☐ Y ☐ N Are there any smokers in the household?

☐ Y ☐ N Has your child ever been hospitalized? If so, what was the reason? ________________

☐ Y ☐ N Has your child ever had surgery?

If yes, please list: ____

☐ Y ☐ N Are your child's immunizations up to date?

Has your child ever had any of the following problems or seen a physician for:

☐ Y ☐ N Seizures

☐ Y ☐ N Heart Murmur

☐ Y ☐ N Heart Problems

☐ Y ☐ N Lung Promblems (asthma, cystic fibrosis, other) ________________

☐ Y ☐ N Bronchopulmonary Dysplasia

☐ Y ☐ N Endocrine Problems

☐ Y ☐ N Diabetes/Thyroid

☐ Y ☐ N Stomach Problems

☐ Y ☐ N Gastroesophageal Reflux

☐ Y ☐ N Enuresis (Bedwetting)

☐ Y ☐ N Skin Problems

☐ Y ☐ N Kidney/Bladder Problems

☐ Y ☐ N Muscle/Bone Problems

☐ Y ☐ N Immune Disorders

If yes to any of the above, please explain: ____

Social History:

☐ Y ☐ N Does your child attend daycare/preschool?

Age when entered ______ # of children in room/class ________

Grade in School ______

Which family members live with the patient? ☐ Mother ☐ Father ☐ Step Parent

RESET FORM

Number of: Brothers ______ Sisters ______ Other ______