MEDICAL HISTORY FORM

PENTA
Pediatric ENT of Atlanta
Where Children Are First™

Patient Name ________________ ________________ ________________ Date ______/______/________
First Middle Last

Age ______ DOB ______/______/________ Weight ____________ lbs.

Allergies to medications: ❍ Y ❍ N If yes, please list: ________________________________

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 yes, 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 Problems (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 ❍ Other ________________

# of Brothers ________ # of Sisters _______