The Toledo Clinic | ENT

Pediatric History Form

Please Fill Out Both Sides of Form

Patient Name ______________________________ Sex ☐ M ☐ F

First MI Last

Date of Birth ________________ Age __________

Pharmacy Name ____________________ Pharmacy Phone ____________________

Name of Parent / Guardian (minors only) ______________________________

Primary Care Physician ______________________________

Reason for Referral ______________________________

Onset of Symptoms ______________________________

Allergies to Medications ______________________________

Patient History

Does the patient have:		If yes, please describe:	
ADD/ADHD	☐ Yes ☐ No		
Food Allergies	☐ Yes ☐ No		
Seasonal Allergies / Hay Fever	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
Ear Infections	☐ Yes ☐ No		
Hearing Problems	☐ Yes ☐ No		
Sinus Problems	☐ Yes ☐ No		
Snoring	☐ Yes ☐ No		
Strep Throat	☐ Yes ☐ No		
Tonsillitis	☐ Yes ☐ No		
Bleeding Tendencies	☐ Yes ☐ No		
Bronchitis / Pneumonia	☐ Yes ☐ No		
Diabetes / Hypoglycemia	☐ Yes ☐ No		
Heart Problems	☐ Yes ☐ No		
High Blood Pressure	☐ Yes ☐ No		
Lung Problems	☐ Yes ☐ No		
Seizures / Convulsions	☐ Yes ☐ No		
Yeast or Fungal Infections	☐ Yes ☐ No		
Complications with Surgery or Anesthesia	☐ Yes ☐ No		
Immunizations up to Date	☐ Yes ☐ No		
Exposed to Tobacco Smoke If yes, who, how much	☐ Yes ☐ No		
History of Cancer	☐ Yes ☐ No	When	What Type
		Year Dx	Treatment
Pass Newborn Hearing Screening	☐ Yes ☐ No		

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Current Medications? ______________________________

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____

____

Over the Counter / Herbal Medications ______________________________

____

____

Surgical History

Type of Surgery	Year of Surgery	Right/Left

Family History

If yes, please indicate their relationship to patient
(ex: father, mother, sister, brother., etc.)

Asthma	☐ Yes ☐ No	
Bleeding Tendencies	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Ear Infections	☐ Yes ☐ No	
Ear Surgeries	☐ Yes ☐ No	
Hearing Problems	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
Seasonal Allergies / Hay Fever	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Sinus Problems	☐ Yes ☐ No	
Thyroid Disorder	☐ Yes ☐ No	

Other problems / conditions the physician needs to be aware of ______________________________

____

Reviewed by ______________________________ (staff) Date ______________

Reviewed by ______________________________ (physician) Date ______________