OTOLARYNGOLOGY/ENT
3030 Children's Way Ste. 402
San Diego, CA 92123

The following information is important. Please be as complete as possible. Information is strictly confidential and will not be released without your written consent. Please be aware that the information typed into this form cannot be saved to your computer. After completing, print out and bring to your appointment.

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Current Weight: _____

You are bringing your child to the ENT doctor because of concerns about:

The problem first started: _____

Medication your child is currently using: _____ _____

Medication Dose

My child is allergic to the following: _____ _____

Medication Dose

_____ _____

Medication Dose

My child has been hospitalized for: _____ _____

Reason Date

Prior Antibiotic usage: (check all that apply)

☐ **Ampicillin**	☐ **Cedax**	☐ **Keflex**	☐ **Suprax**
☐ **Amoxicillin**	☐ **Cefzil**	☐**Lorabid**	☐ **Vantin**
☐ **Augmentin**	☐ **Clindamycin**	☐ **Omnicef**	☐ **Zithromax**
☐ **Bactrim**	☐ **Duricef**	☐ **Pediazole**	☐ **Other**
☐ **Biaxin**	☐ **Erythromycin**	☐ **Penicillin**	_____
☐ **Ceclor**	☐ **Gantrisin**	☐ **Septra**	

My child does not tolerate: _____

Reason: _____

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Name of Patient: _____ DOB: _____

Are your child's immunizations up to date? Yes ☐ No ☐

Other medical Problems: (check all that apply)

☐ **Allergies-Food/Environmental**	☐ **Developmental Delay**	☐ **Kidney problems**
☐ **Asthma**	☐ **Down's syndrome**	☐ **Pneumonia**
☐ **Attention Deficit Disorder**	☐ **Reflux**	☐ **Seizure Disorder**
☐ **Cerebral Palsy**	☐ **Heart Defect**	☐ **Speech Delay**
☐ **Croup**	☐ **Heart murmur**	

List all other medical problems:

Are there any bleeding problems in the patient? Yes ☐ No ☐ Describe: _____

Are there any bleeding problems in the Family? Yes ☐ No ☐ Describe: _____

Is the child exposed to cigarette smoke? Yes ☐ No ☐ Describe: _____

Is the child in Daycare? Yes ☐ No ☐ # of children: _____ Days per week: _____

Birth History: (check all that apply)

☐ Prematurity ☐ Neonatal Respiratory problems ☐ NICU stay ☐ Intubation ☐ Other

Describe: _____

Birth Weight: _____

Family History:

Environmental Allergies Yes ☐ No ☐ if yes, who? _____

Asthma Yes ☐ No ☐ if yes, who? _____

Ear problems Yes ☐ No ☐ if yes, who? _____

Have siblings been seen in the office?

Yes ☐ No ☐ Name: _____

Family Pharmacy: _____ Phone#: _____

Signature: _____ _____ _____

PARENT/LEGAL GUARDIAN PLEASE SIGN **RELATION** **DATE**