Pediatric ENT Associates

PEDIATRIC DEMOGRAPHICS

DATE: _____

(Please Print)

PATIENT

Last Name	First Name	Middle Initial	Social Security No.	Sex	Date of Birth
				□Male □Female	/ /

Phone Number	Street Adress	City	State	Zip Code

Parent Status	Legal Custody of Patient
□ Married □Separated □Divorced □Single □Foster Care □Adoptive	□Both Parents □Mother □Father □Other….
Patient adopted/Foster child: □ Adopted □ Foster child	Name/Relationship:

Race	Ethnicity	Primary Language
□White □African American □Asian □Native AmericanAsian □Other/decline	□Spanish/Hispanic Orgin □Not of Hispanic Orgin □Decline	□English □Spanish □Other □Decline

List All Doctors that the patient sees (please include contact number)	Caseworker & contact number (if applicable)

Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

Emergency Contact Name/Relationship	Emergency Contact Address	Emergency Contact Phone Numbers
		Home: Cell:

INSURANCE

Primary Insurance:
Who carries this insurance (Guarantor): Name Relationship:
Secondary Insurance:
Who carries this insurance (Guarantor): Name Relationship:

Please circle MOTHER/FATHER/GUARDIAN

Last Name	First Name	Middle Initial	Social Security No.	Sex	Date of Birth
				□Male □Female	/ /

Street Address	City	State	Zip Code	Occupation

Home Phone	Work Phone	Cell Phone	Email Address

Employer Name and Address	Employer Phone Number

Please circle MOTHER/FATHER/GUARDIAN

Last Name	First Name	Middle Initial	Social Security No.	Sex	Date of Birth
				□Male □Female	/ /

Street Address	City	State	Zip Code	Occupation

Home Phone	Work Phone	Cell Phone	Email Address

Employer Name and Address	Employer Phone Number

every child shines

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ALLERGIES

My child has NO medication allergies: Check here □

To Medication:	□ No	□ Yes	What_____	Reaction_____
To Environment:	□ No	□ Yes	What_____	Reaction_____
To Food:	□ No	□ Yes	What_____	Reaction_____

LIST THE FOLLOWING MEDICATION THE PATIENT IS TAKING ALL THE TIME OR AS NEEDED:

* Medications prescribed by your doctors, OTC (over the counter), supplements or herbals

Name of Medication	Dose	(If you are unsure, please bring medications or list from pharmacist)
1		
2		
3		
4		
5		

DID THE PATIENT HAVE ANY OF THESE CHILDHOOD ILLNESSES?

□ Bronchiolitis	□ RSV	□ Tonsillitis
□ Croup	□ Febrile Seizure	□ MRSA
□ Infant Reflux	□ Ear Infections	□ URI
□ Mononucleosis	□ Strep Throat	□ Sinus Infection
□ Premature Birth/How many weeks early?		

DOES THE PATIENT HAVE?

□ ADHD	□ Cancer	□ Epilepsy/Seizures
□ Allergies	□ Cerebral Palsy	□ Esophageal Reflux
□ Asthma	□ Cystic Fibrosis	□ Heart Murmur/Defect
□ Autism	□ Depression	□ Sickle Cell disease
□ Birth Defects	□ Diabetes	□ Sleep Apnea
□ Bleeding Problems	□ Down Syndrome	□ Other (Please list below)

HAS THE PATIENT HAD ANY SURGERIES? □ Yes □ No (If yes, please list with date or age)

SURGERY	DATE	SURGEON	FACILITY
1			
2			
3			
4			

DID THE PATIENT HAVE ANY DIFFICULTIES WITH ANESTHESIA? □ Yes □ No

DID THE PATIENT HAVE ANY DIFFICULTIES WITH SURGERY? □ Yes □ No

HAS THE PATIENT HAD ANY MAJOR HOSPITALIZATIONS? □ Yes □No

If yes, please list:

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IMMEDIATE FAMILY HISTORY (MOTHER, FATHER, SISTER OR BROTHER)

Does anyone in your **IMMEDIATE FAMILY (NOT THE PATIENT)** have any of the following:

			Family Member
Severe Reactions to Anesthesia (e.g. Malignant Hyperthermia)	□ Yes	□ No	_____
Birth Defects (Cleft Lip/Palate, Down Syndrome, Birthmarks)	□ Yes	□ No	_____
Bleeding After Tonsillectomy ----------	□ Yes	□No	_____
Bleeding Problems (e.g. Factor V/Von Willebrands)----------	□ Yes	□No	_____
Hearing Loss ----------	□ Yes	□No	_____
Acid Reflux ----------	□ Yes	□No	_____
Allergies ----------	□ Yes	□No	_____
Asthma ----------	□ Yes	□No	_____
IS THE PATIENT ADOPTED?	□ **Yes**	□**No**	
WHO DOES THE PATIENT LIVE WITH?	□ Mother □Father	□ Other	

ENVIRONMENT

Are there any pets in the household? ----------	□ Yes	□ No
	If yes, what kind?	
Do you think the patient has allergies? ----------	□ Yes	□ No
Does anyone who cares for the patient smoke? ----------	□ Yes	□ No
Is the patient in daycare? ----------	□ Yes	□ No
Is the patient in special education? ----------	□ Yes	□ No
Is the patient in school? ----------	□ Yes	□ No
	If yes, what grade?	
Is the patient in special therapies? ----------	□ Yes	□ No
Circle those that apply: OT PT SPEECH		
Academic Concerns? ----------	□ Yes	□ No
Does the patient get regular exercise? ----------	□ Yes	□ No
Sports/Hobbies (Please list)		

FOR INFANTS & YOUNG CHILDREN TO AGE 8 ONLY

Is/Was child breastfed? ----------	□ Yes	□ No
	If yes, how long?	
Does the child use a pacifier? ----------	□ Yes	□ No
	If yes, when?	
Does the child use a bottle? ----------	□ Yes	□ No
If yes, Is the bottle used while laying down?	□ Yes	□ No
Type of formula?		
Did child pass his/her newborn hearing screen?	□ Yes	□ No