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PENTA
Pediatric Ear, Nose & Throat Associates

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:

MOTHER/FATHER/GUARDIAN

Please circle

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

MOTHER/FATHER/GUARDIAN

Please circle

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

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PATIENT MEDICAL INFORMATION

NAME:
DATE:

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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FAMILY AND SOCIAL HISTORY

NAME:
DATE:

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 □ Unknown

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IMPORTANT: NO MATTER WHY YOU ARE HERE:
CHECK ALL SYMPTOMS WHICH WERE ONGOING DURING THE LAST 6 MONTHS

PLEASE TELL US REASONS WHY YOUR CHILD CAME TO THE DOCTOR TODAY: (Check all that apply)		
□ Cough	□ Large Adenoids and Tonsils	□ Sinus Infections
□ Ear infection	□ Nosebleeds	□ Speech problems
□ Feeding/ Swallowing problems	□ Noisy Breathing	□ Tongue tie
□ Hearing Concerns	□ Reflux	□ Trouble Sleeping

DOES YOUR CHILD HAVE:	(Please Check all that apply)	
□ Fever	□ Bad Breath	□ Birthmarks
□ Bed Wetting	□ Choking	□ Dry Skin
□ Appetite Change	□ Dental Problems	□ Eczema
□ Excessive Sleepiness	□ Difficulty Swallowing	□ Rashes
□ Hard to Awake	□ Drooling	□ Behavior Changes
□ Night Awakening	□ Gagging	□ Speech Delay
□ Sleeping Difficulties	□ Hoarseness	□ Developmental Delays
□ Restless Sleep	□ Sore Throat	□ Difficulty Walking
□ Weight Gain	□ Throat Clearing	□ Difficulty with Balance
□ Weight Loss	□ Throat Infection/Strep	□ Dizziness
□ Trouble Gaining Weight	□ Tongue Lesion	□ Headaches
□ Crossed Eyes	□ Tongue Tied	□ Seizures
□ Itchy Eyes	□ Chest Pain	□ Unclear Speech
□ Eye Redness	□ Heart Murmurs	□ ADHD
□ Eye Swelling	□ Cough	□ Social/Behavior Problem
□ Ear wax buildup	□ Croup	□ Diabetes
□ Ear Drainage	□ Difficulty Breathing	□ Thyroid Problems
□ Ear Infection	□ Noisy Breathing	□ Bleeding/Bruising
□ Chronic	□ Pneumonia	□ Bleeding- during/after surgery
□ Recent	□ Stops Breathing	□ Sickle Cell Anemia
□ Ear Pain	□ Turns Blue	□ Asthma
□ Difficulty Hearing	□ Wheezing	□ Food Sensitivities/Allergy
□ Hearing Loss	□ Constipation	□ Hay Fever
□ Nose Bleeds	□ Difficulty Eating	□ Hives
□ Congestion	□ Frequent Burping	□ Masses in Neck/Lump
□ Stuffy Nose	□ Heartburn	□ Neck Swelling/Enlarged Lymph nodes
□ Mouth Breathing	□ Hiccups	
□ Post Nasal Drip	□ Spitting Up	
□ Running Nose	□ Indigestion	
□ Sneezing	□ Nausea	
□ Sniffing	□ Stomach Aches	
□ Snoring	□ Vomiting (Frequent)	
□ Snorting	□ Wet Burps	
□ Trouble Breathing	□ Joint Pain	

CHECK HERE: IS YOUR CHILD:			
□ Eating OK	□ Sleeping OK	□ Moving/Walking OK	□ Talking OK