BOSTON ENT ASSOCIATES ***Today's Date:_____***

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Name:_____ Date of Birth:_____Age:_____

Pediatrician: _____ Hospital Affiliation:_____

What is your primary reason for today's visit?_____

MEDICAL HISTORY

Does your child have a history of (please circle): *Asthma Heart Disease Diabetes NONE*

Please list any other medical conditions child may have:☐ *no medical conditions*

Any problems or complications with pregnancy or delivery? ☐*none*

Operations of the ears, nose, throat, head or neck: ☐ *none*

MEDICATIONS

List current medications (or provide list if available):☐ *no current medications*

Please list ALLERGIES to medications or anesthesia: ☐ *no known allergies*

Your doctor will send your prescriptions electronically to your pharmacy. Please provide pharmacy information: *CVS Walgreens Rite-Aid Costco Target Other*:_____

***Street/City*:_____**

SOCIAL and FAMILY HISTORY

Does anyone in the home smoke? YES or NO

Does child have a family history of hearing loss under age 65, cancer of the head and neck, or bleeding disorders, or reactions to general anesthesia? Or NONE

Child's current height and weight: _____ lbs. ____ ft. ____ inches

Does the child currently experience any of the following (please circle):

Fever Unexplained weight loss Unexplained weight gain Double Vision Itching eyes

Hearing Loss Frequent nosebleeds Sore throat Snoring Dry Mouth Difficulty Swallowing Hoarseness

Headaches Seizures Chest Pain Palpitations Wheezing Shortness of Breath

Heartburn Nausea Easy Bruising Bleeding problems Depression Anxiety Muscle Aches Joint Pain

Rashes Itching Dry Skin Heat/Cold Intolerance