Dallas ENT Group

Pediatric Ambulatory History

Patient Name ________________________________DOB____________Age ___Today's Date________

Pharmacy Name: Phone #

Referring Physician or who may we thank for referring you?

What is the ***reason*** your child is being evaluated and how long has he/she has this problem?

Present Weight:

Please respond for all infants less than one year of age or those infants that experienced neonatal complications:

Was the infant full term? Gestational age at birth.

Birth weigh

Problems during pregnancy? Please describe.

Days spent in the neonatal nursery

Was your child admitted to the Neonatal Intensive Care
If yes, how long and for what reason?

Did your child pass the hearing screen in the Newborn nursery?

Please respond for all infants and children:

Present medications:

Allergies to medications:

Previous surgery:

Previous hospitalizations:

Please list and *explain* if your child has experienced problems with the following:

Vomiting
Choking
Recurrent Pneumonia or RSV
Persistent Cough (wet or dry)
Mouth Breathing and/or snoring
Cyanotic episode (turning blue)
Airway noise (anytime)
Airway noise after eating
Wheezing
Recurrent ear infections or drainage
Recurrent nasal infection with yellow-green nasal drainage
Speech or Language delay (therapy?)
Bleeding problems or family history of bleeding problems?
Problems with anesthesia or family history of anesthesia problems?

Is your child under the care of another Pediatric Specialist? If so, please explain.

PATIENT SIGNATURE (Parent, if minor) ________________________relationship __________