# ENT CASE HISTORY

Date: _____ Patient Name: _____ Date of Birth: _____

Pediatrician/Family physician: _____

Pharmacy Name & Address: _____ Phone: _____

Have you ever seen one of our providers in the past? ◯ Yes ◯ No
Are your child's immunizations up to date? ◯ Yes ◯ No
Is the child exposed to second hand smoke? ◯ Yes ◯ No

Surgical History:

◯ Patient has had no surgeries ◯ Sinus surgery ◯ Airway surgery ◯ VP shunt
◯ Ear surgery ◯ Ear tube insertion ◯ Tonsils removed ◯ Other: _____
◯ Cleft lip/palate repair ◯ Heart surgery ◯ Adenoids removed

Allergies: ◯ No known allergies _____

Medications: ◯ No medications at this time _____

_____

**Please check any symptom below that is currently a problem for the patient:**

**General:**
- ◯ Fevers
- ◯ Chills
- ◯ Swelling
- ◯ Anorexia
- ◯ Fatigue
- ◯ Sleepiness
- ◯ Sleep problems
- ◯ Malaise
- ◯ Weight gain
- ◯ Weight loss
- ◯ Speech delay

**Eyes:**
- ◯ Eye pain
- ◯ Vision loss
- ◯ Excessive tears
- ◯ Blurring
- ◯ Diplopia
- ◯ Irritation
- ◯ Discharge
- ◯ Photophobia

**Genitourinary:**
- ◯ Urinary tract infections
- ◯ Incontinence

**Ears/Nose/Throat:**
- ◯ Ear pain/discharge
- ◯ Tinnitus
- ◯ Decreased hearing
- ◯ Nasal obstruction or discharge
- ◯ Nosebleeds
- ◯ Sore throat
- ◯ Hoarseness
- ◯ Difficulty swallowing

**Cardiovascular:**
- ◯ Chest pain
- ◯ Palpitations
- ◯ Syncope
- ◯ Dyspnea on exertion
- ◯ Orthopnea
- ◯ Peripheral edema

**Respiratory:**
- ◯ Cough
- ◯ Difficulty breathing
- ◯ Excessive sputum
- ◯ Hemoptysis
- ◯ Wheezing

**Gastrointestinal:**
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Change in bowel habits
- ◯ Abdominal pain
- ◯ Melena
- ◯ Hematochezia
- ◯ Jaundice

**Musculoskeletal:**
- ◯ Back pain
- ◯ Joint pain
- ◯ Joint swelling
- ◯ Muscle cramps
- ◯ Muscle weakness
- ◯ Stiffness

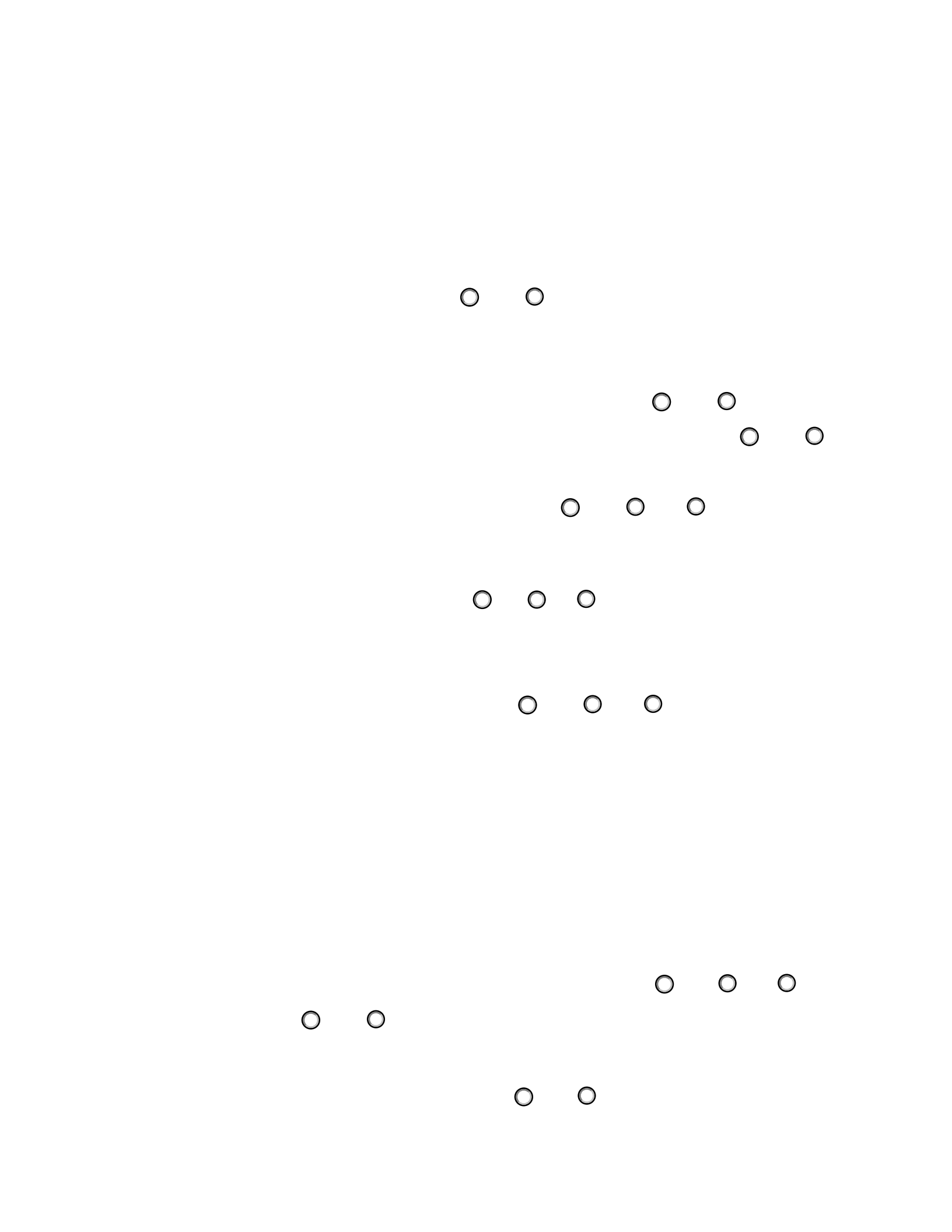
**Skin:**
- ◯ Rash
- ◯ Itching
- ◯ Ulcers/growths
- ◯ Excessive scarring
- ◯ Bleeding problems
- ◯ Dryness
- ◯ Suspicious lesions

**Neurologic:**
- ◯ Paralysis
- ◯ Weakness
- ◯ Seizures
- ◯ Syncope
- ◯ Tremors
- ◯ Vertigo

**Psychiatric:**
- ◯ Depression
- ◯ Anxiety
- ◯ Memory loss
- ◯ Mental disturbance
- ◯ Suicidal ideation
- ◯ Hallucinations
- ◯ Paranoia

**Endocrine:**
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Polydipsia
- ◯ Polyphagia
- ◯ Polyuria
- ◯ Weight changes

**Heme/lymphatic:**
- ◯ Abnormal bruising
- ◯ Bleeding
- ◯ Enlarged lymph nodes



pediatric ENT
OF OKLAHOMA

# Checking Patient Information

**Patient Name:** _____ **Patient Date of Birth:** _____

**Currently using the same insurance as before:** ◯ **YES** ◯ **NO**

**If NO, please complete the following:**

**Insured's Name:** _____ **Insured's Date of Birth:** _____

**Plan Name:** _____ **Policy Number:** _____

**Insured's SSN:** _____

**Do you have a secondary insurance? If YES, please fill in the secondary insurance:**

**Insured's Name:** _____ **Insured's Date of Birth:** _____

**Plan Name:** _____ **Policy Number:** _____

**Insured's SSN:** _____

**My current address is:** _____

_____

**Current phone number:** _____

**Parent/Guardian Signature:** _____ **Date:** _____

**Staff Member Signature:**_____ **Date:** _____