S. C. E. N. T. A

Space Coast Ear Nose & Throat, Associates

PEDIATRIC MEDICAL HISTORY

NAME: _____ Primary Care Dr: _____

REASON FOR TODAY'S VISIT:

_____

Please indicate if patient has history of the following:

	Allergies, Environmental/Food		**Cancer or Leukemia Type:**		**Reflux**
	Asthma		**Eczema / Skin rashes**		**Snoring**
	Autism		**Headaches**		**Strep Throat, chronic**
	Bleeding disorder		**Hearing Loss / Deaf**		**Sleep Apnea**
	Diabetes		**Heart Condition**		**Speech Delay**
	Ear infections		**Learning disabilities**		**Thyroid disorder**

Any other conditions:

_____

Diagnosed with any developmental delay? YES / NO

If yes, what kind? _____

CURRENT MEDICATIONS: *Please include any over- the-counter and supplements*

_____ _____

_____ _____

Over--→

Is your child allergic to any medications? YES NO

If yes, what medications? Reaction?

_____ _____

_____ _____

Food allergies? If yes, please list:

_____ _____

What pharmacy do you use? _____

Please list any surgeries child has had, and the approximate year done:

_____ _____

_____ _____

Has child been hospitalization for any illness or injuries? Yes / No

If yes, please indicate condition and approximate year:

_____ _____

_____ _____

Please circle if child is currently undergoing:

Speech / Occupational / Physical Therapy

BIRTH HISTORY

Child was born: PREMATURE ___ FULL TERM ____

Birth Weight ___lbs ___oz.

Delivered with: No complications___ NICU stay_

SOCIAL HISTORY

Are immunizations up to date? Yes Behind Refused

Does child attend daycare? YES /NO

If yes, how many days weekly? _____

Is your child/adolescent:

Attending school ___ Home schooled ___ Virtual schooled ____

Adult Ed ____

Is your child exposed to any second hand smoke? YES / NO

Does child drink caffiene? Yes / No

If yes, what kind? Coffee___ Tea___ Soda___ Energy drinks__

How many a day or week? _____

**Young adult females:*

Has menstruation begun? Yes /No

FAMILY HISTORY

Does child have any siblings? YES / NO

If so, how many? Brothers _____ Sisters _____

Over--→

Please indicate by checking off below if any close family members have been diagnosed with the following conditions:

Medical Condition	Mother	Father	Siblings	Grands
Allergies				
Asthma				
Bleeding/Clotting disorder				
Cancer, what type?				
Diabetes				
Headaches				
Hearing loss				
High blood pressure				
High Cholesterol				
Heart Disease				
Kidney disease				
Lung Disease				
Mental Illness				
Seizures				
Stroke				
Thyroid Disorder				

All done, thank you!

Staff use--Ht/Wt: *B/P:* *P:* *R:* *O2 Sat:*