

CHILD MEDICAL HISTORY

Patient's Name _____ DOB _____ Today's Date _____

Allergies to medications: Y N Allergies to foods: Y N

If yes, please list: _____

Current Medications: _____

Pharmacy's Name: _____

Child's Medical History:

- Y N Is there a family history of bleeding problems?
- Y N Does your child have a history of bleeding problems?
- Y N Is there a family history of anesthesia problems? If yes, please explain: _____
- Y N Are there other family history issues? (e.g., hearing loss, sleep apnea, cancer, etc.)
If yes, please explain: _____
- Y N Are there any smokers in the household?
- Y N Has your child ever been hospitalized? If so, what was the reason? _____
- Y N Has your child ever had surgery?
If yes, please explain: _____
- Y N Are your child's immunizations up to date?

Has your child ever had any of the following problems or seen a physician for:

- Y N Seizures
- Y N Heart Murmur
- Y N Heart Problems
- Y N Lung Problems (asthma, cystic fibrosis, other) _____
- Y N Bronchopulmonary Dysplasia
- Y N Endocrine Problems
- Y N Diabetes/Thyroid
- Y N Stomach Problems
- Y N Gastroesophageal Reflux
- Y N Enuresis (Bedwetting)
- Y N Skin Problems
- Y N Kidney/Bladder Problems
- Y N Muscle/Bone Problems
- Y N Immune Disorders

If yes to any of the above, please explain: _____

Social History:

- Y N Does your child attend daycare/preschool?
Grade in School _____

Parent / Guardian Signature _____ Date _____



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Communication Form

I give permission for the following person(s) to receive information regarding my appointments, medical care and/or release of medical records:

	NAME	PHONE	RELATIONSHIP	EMERGENCY CONTACT
1.	_____	_____	_____	<input type="checkbox"/>
2.	_____	_____	_____	<input type="checkbox"/>
3.	_____	_____	_____	<input type="checkbox"/>

This form of communication will be used as the standard until revoked in writing by patient.

Patient/Guardian Signature: _____

Date signed: _____