

ENT Clinic of Iowa, P.C.
1455 29th Street
Des Moines, IA 50266

ENT Clinic of Iowa, P.C.
601 E. Locust St., Suite 201
Des Moines, IA 50309

Children's Medical History (0-12 Years Old)

Name _____ Today's Date _____

Date of Last Physical Exam _____ Physician's Name _____

Drug Allergies _____

Medications (currently taking) _____

Surgeries _____

Where there any problems with the anesthesia? (Please explain) _____

Prior Hospitalizations _____

Age _____ Weight _____ Height _____

Does your child have or had in the past year any of the following?

Hearing Loss	Yes/No	Discharge from ears	Yes/No
Frequent ear infections	Yes/No	How often? _____	
What were they treated with? _____			
Failed hearing test	Yes/No	Earaches	Yes/No
Delayed speech	Yes/No	Sinus problems	Yes/No
Chronic nasal congestion	Yes/No	Allergies/hay fever	Yes/No
Headaches	Yes/No	To what? _____	
Nosebleeds	Yes/No		
Frequent sore throats	Yes/No	History of strep throat	Yes/No
Snoring	Yes/No	Chronic cough	Yes/No
Periods when the child stops breathing		Asthma	Yes/No
While sleeping	Yes/No	Other _____	
Are immunizations up to date?	Yes/No		

Past infections: _____

Has your child had any: Heart Problems Yes/No (If yes, please explain) _____
Lung Problems Yes/No (If yes, please explain) _____
Pneumonia Yes/No (If yes, when) _____

(Over)

Renal Problems Yes/No (If yes, please explain) _____

Gastrointestinal Problems Yes/No (If yes, please explain) _____

Fever, chills or weight loss? _____

Neurological Problems:

Meningitis Yes/No

Head Injury Yes/No

Epilepsy Yes/No

Headaches Yes/No

Dizziness Yes/No

Immune/Endocrine Systems:

Diabetes Yes/No

AIDS (HIV Positive) Yes/No

Hemophilia (bleeding) Yes/No

Enlarged glands Yes/No

Were there any problems after the child's birth? _____

Family History:

Father's age _____ Health (circle one) Good Fair Poor

Mother's age _____ Good Fair Poor

Brother's age(s) _____ Good Fair Poor

Sister's age(s) _____ Good Fair Poor

Social History:

Does the child attend daycare? Yes/No

Is the child around any pets? Yes/No If so, what type? _____

Is the child around anyone who smokes? Yes/No

What grade level are they in school? _____

Has any relative ever had the following: (mother, father, grandparents & siblings)

Cancer Yes/No Diabetes Yes/No

High Blood Pressure Yes/No Heart trouble Yes/No

Hemophilia Yes/No Epilepsy Yes/No

Stroke Yes/No

Is there a family history of problems with general anesthesia? Yes/No

Other _____

Thank you for taking the time to complete this information for your child.