RANSOM MEMORIAL HOSPITAL

ENT/AUDIO PEDIATRIC PATIENT HISTORY FORM

1402 S. Main Street, Ottawa, KS 66067
785-229-3390

Patient Name_____**DOB:**_____**Age:**_____

Referring/Regular Physician:_____Pharmacy: _____

Reason for today's visit_____Weight: _____ Height: _____

Are you having any pain? ☐**YES** ☐**NO** Rate your pain on a scale from **1 – 10** _____ **10** as worst?

Have you fallen in the last 6 months? ☐**YES** ☐**NO** Injury_____

List medications child is taking: _____

List any drug allergies: _____

SOCIAL HISTORY:

Does anyone in the house smoke? ☐**YES** ☐**NO** Does the child attend daycare? ☐**YES** ☐**NO** **Grade**_____

FAMILY HISTORY: Is the child in foster care, adopted or under non-parental guardianship? ☐YES ☐NO

Mother: ☐Living ☐Deceased | Father: ☐Living ☐Deceased | Siblings: ☐Living ☐Deceased

	Mother	*Father*	*Siblings*		*Mother*	*Father*	*Siblings*		*Mother*	*Father*	*Siblings*
Hypertension	☐	☐	☐	Asthma	☐	☐	☐	Free Bleeding	☐	☐	☐
Hepatitis	☐	☐	☐	Allergies/Hay Fever	☐	☐	☐	Heart Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐	Cancer	☐	☐	☐	Hearing Loss	☐	☐	☐
Diabetes	☐	☐	☐	Tuberculosis	☐	☐	☐	Anesthesia Reaction	☐	☐	☐

PAST MEDICAL HISTORY: ***(Does the child have a history of the following?)***

Child's immunizations up-to-date? ☐**YES** ☐**NO** Is Childs growth and development normal? ☐**YES** ☐**NO**

Was child premature or any other complications associated with birth? ☐**YES** ☐**NO**

If yes, please explain_____

Does your child have a known Latex allergy? ☐**YES** ☐**NO**

Has your child had any problem tolerating anesthesia? ☐**YES** ☐**NO**

❑ Heart Murmur	❑ Fever	❑ Possible speech delay	❑ Persistent cough
❑ Anemia	❑ Diabetes	❑ Mouth Breathing	❑ Snoring
❑ Sleep Apnea	❑ Asthma	❑ Nasal Congestion	❑ Nasal Drainage
❑ Nose Bleeds	❑ Easy bleeder	❑ HIV/AIDS/Exposure to AIDS	❑ Meningitis
❑ Constipation	❑ Diarrhea	❑ Bed wetting	

❑ Ear Pain/Ear Infections # Year_____ ❑ Sore Throat/Tonsillitis # Year_____

Please list any illnesses, hospitalizations, or surgeries past and present:_____