Children's Ear Nose & Throat Center

Sub-specialists of Dell Children's Medical Center of Central Texas

A member of the Seton Family of Hospitals

3705 Medical Parkway, Suite 200 • Austin, Texas 78705 Office: (512) 452-0231 • Fax: (512) 452-8083

NEW PATII	ENT INFORMATI	ON
Visit Data:		
Visit Date: Patient Name:	Age.	DOB.
Relationship to Patient:		
Health Problem Prompting Today's Vis	sit:	
Patient Medical History:		
Please list past and current medical p	problems:	
Please list past surgeries:		
Please list all current medications (pre herbs:	scription and non-pr	escription), vitamins, &
Medication allergies: None: Ye	es: (if yes, plea	se list type of reaction):
Please indicate if ANYONE in the fam Trouble with anesthesia? No	•	h the following:
Bleeding problems? No	Yes Explain .	
Other family medical issues? No	Yes Explain	

Birth history: Full Term? gestation?	No	Yes	If no, how r	nany weeks
Immunizations: Up-to-date?	No	Yes		
Exposure to smoking?	No	Yes		
Daycare?		Yes		
School?	No	Yes		
Does your CHILD have any o	f the followi	ng proble	ms?:	
Heart	No Yes	_ Explain		
Lungs	No Yes	_ Explain		
Kidney/Urinary tract 1	No Yes	_ Explain		
Muscles/joints 1	No Yes	_ Explain		
Eye/Vision 1	No Yes	_ Explain		
Allergic/Immune 1	No Yes	_ Explain		
	No Yes	_ Explain		
9		•		
Psychologic Problems 1	No Yes	_ Explain		
Weight loss	No Yes	_ Explain		
Fevers	Vo Yes	_ Explain		
Any pain on today's visit?	No Yes	_ If Y	es, please cir	cle score below:
PAIN RATING SCALE (0=No	pain, 10=M	ost Sever	e)	
0 1 2 3 4	5 6	7	8 9	10
Physician Review				Date
Vital Signs: Weight	_ Temp	RR		BP