

CROWN Otolaryngology Pediatric Intake Form Section 1

Child's Name _____ Date of Birth _____
First Last

Referring Physician _____ Today's Date _____

List your child's pediatrician name and phone #: _____

Preferred Pharmacy _____ Pharmacy Phone _____

Pharmacy Address _____

What is the reason for your child's visit today? _____

If chronic sinusitis, please ask for questionnaire

Asthma Yes No Respiratory Allergies Yes No Food Allergies Yes No

Other (please describe): _____

Does your child have any allergies? Yes ___ No ___ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

If your child's problem causes pain, where is it painful? _____ How long has it been present? _____

Description of pain _____ When does it occur? _____ Severity _____

Any other symptoms? _____ What makes it better or worse? _____

Please list ALL of your child's current medications below (use back of page if you need more room)

Medication Name	Dose	When is it given?	Approximate start date of medication

Does your child take any non-prescription medications? Yes ___ No ___ If yes, list: _____

BIRTH HISTORY

Which pregnancy is this child? _____ Did the mother have health problems during the pregnancy? Yes ___ No ___

Describe: _____

Born by vaginal delivery or c/section? _____ If c/section, reason _____

How many months' gestation at birth? _____ Birth weight _____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc) _____

Is your child adopted? Yes ___ No ___ If Yes, please describe the above to the best of your knowledge.

MEDICAL HISTORY: HAS YOUR CHILD EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING? (describe):

- Anemia: Yes ___ No ___ _____
- Asthma/Breathing Problems: Yes ___ No ___ _____
- Allergies: Yes ___ No ___ _____
- Arthritis: Yes ___ No ___ _____
- Behavioral Problems: Yes ___ No ___ _____
- Bleeding Tendency: Yes ___ No ___ _____
- Bowel Problems: Yes ___ No ___ _____

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MEDICAL HISTORY continued:

Cancer/Leukemia: Yes ___ No ___ _____

Chicken Pox/Shingles: Yes ___ No ___ _____

Developmental Disorder: Yes ___ No ___ _____

Diabetes: Yes ___ No ___ _____

Ear/Nose/Throat(ENT) Disorder: Yes ___ No ___ _____

Eczema/Skin Disorder: Yes ___ No ___ _____

Eye Disorder : Yes ___ No ___ _____

Growth Disorder: Yes ___ No ___ _____

Heart Disorder/Defect: Yes ___ No ___ _____

High Blood Pressure: Yes ___ No ___ _____

High Cholesterol: Yes ___ No ___ _____

Immune Deficiency Disorder: Yes ___ No ___ _____

Kidney/Urinary Disorder: Yes ___ No ___ _____

Liver Disease: Yes ___ No ___ _____

Seizure: Yes ___ No ___ _____

Thyroid Disorder: Yes ___ No ___ _____

Any Other? Yes ___ No ___ _____

FAMILY HISTORY: Does your child have any family members with a history of major illness or conditions? List below:

RELATIVE	CONDITION & DESCRIPTION	LIVING (Y/N)	IF DECEASED, AT WHAT AGE?
First name Mother:			
Father: First name			
Siblings:			
Grandparent:			
Grandparent:			
Other:			

SURGICAL HISTORY: List any surgeries your child has had and the approximate date:

Has your child had a blood transfusion? Yes ___ No ___ ? If yes, when? _____

SOCIAL HISTORY:

Mother's Occupation: _____ Marital Status: _____ Spouse's name: _____

Father's Occupation: _____ Marital Status: _____ Spouse's name: _____

Legal Guardian if other than parents: _____

Other people living in the home: _____

Does anyone living in your home smoke? Yes ___ No ___

Have you ever had problems with lead paint or contamination in your home? Yes ___ No ___

Do you have pets in your home? Yes ___ No ___ If Yes, what types? _____

Do you have other children? Yes ___ No ___ If Yes, how many? _____ What are their ages? _____

Parent/Guardian Signature _____ **Date** _____

FOR OFFICE USE ONLY:

CROWN-05-08-09 intake

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):

ALL _____ Problems _____ Allergies _____ Birth Hx _____ Medical Hx _____

Family Hx _____ Surgical Hx _____ Social History _____

Physician Signature _____ Date _____