



UPDATED MEDICAL HISTORY

Today's Date: _____

Child's Name: _____ Preferred Name: _____

Date of Birth: _____ Age _____ Who is with the child today? _____

Insured's Name: _____ Employer Name: _____

Employer Address: _____

Updated Medical Information

Age: _____ Weight: _____ Pulse: _____ Resp: _____

Reason for today's visit: _____

	Yes	No	Update: <i>Ht,Lg,Lv,Kd,Sz,D;All,Neur,GI,M-S,Psy,Cog,other</i>
Any new medical problems ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any recent surgical procedures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any new medication allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current medications (names only)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has s/he seen a doctor for today's problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there a chance that she is pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any change in parent / guardian status?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Updated ENT / Audiology Information

	Yes	No	Update: <i>E-N-T,Voice,H&N</i>
Any changes in hearing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any changes in breathing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any speech or voice changes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any eating or swallowing changes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any new ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any new throat infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any new sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any recent nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	_____

What *specific question(s)* regarding your child's Ear, Nose, and Throat care would you like answered today? _____

Thank you! 😊