Kids ENT of Indiana

Medical Information

Patient Name _____ _____ _____
Last M.I. First

Preferred Pharmacy _____ _____
Name Phone

Primary Care Practitioner _____
Name

Reason for Visit _____

Past Medical History _____
(ex: asthma, reflux, sleep apnea, etc.)

Past Surgical History _____

Current Medications _____

_____

Known Allergies _____
(including medications)

Social History In Daycare ☐ In School ☐ Home School ☐

Smoking in the Home Yes ☐ No ☐ # Siblings _____

Family History	Mother	Father
Alive	☐	☐
Cause of Death		
Allergic to Anesthesia	☐	☐
Bleeding Problems	☐	☐
Hearing Loss	☐	☐
Type of Cancer		