Children's Specialists
of San Diego
A Medical Group

Otolaryngology/ENT
3030 Children's Way, Ste 402
San Diego, CA 92123
WWW.CSSD.US

MEDICAL HISTORY

The following information is important. Please be as complete as possible. Information is strictly confidential and will not be released without your written consent. Be aware that the information typed into this form cannot be saved to your computer. After completing, print out and bring to your appointment.

Name of Patient: Today's date:

Date of Birth: Current Weight:

You are bringing your child to the ENT doctor because of concerns about:

This problem first started:

Medication your child is currently using:

Medication Dose

Medication Dose

My child is allergic to the following:

Medication Reaction

Medication Reaction

My child has been hospitalized for:

Reason Date

Reason Date

Prior Antibiotic usage: *(check all the apply)*

Ampicillin	Cedax	Keflex	Suprax
Amoxicillin	Cefzil	Lorabid	Vantin
Augmentin	Clindamicin	Omnicef	Zithromax
Bactrim	Duricef	Pediazole	Other:
Biaxin	Erythomycin	Penicillin	
Ceclor	Gantrisin	Septra	

My child does not tolerate:

Reaction:

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Name of Patient: DOB:

Are your childs immunizations up to date? Yes No

Other Medical Problems: *(check all that apply)*

Allergies- Food/Environmental	Developmental Delay	Kidney Problems
Asthma	Down Syndrome	Pneumonia
Attention Deficit Disorder	Reflux	Seizure Disorder
Cepebral Palsy	Heart Defect	Speech Delay
Croup	Heart Murmur	

List all other medical problems:

Are there Bleeding problems in the Patient? Yes No Describe:

Are there Bleeding problems in the Family? Yes No Describe:

Is the child exposed to cigarette smoke? Yes No Describe:

Is the Child in daycare? Yes No # of Children: Days per week:

Birth History: *(check all that apply)*

Prematurity Neonatal Respiratory problems NICU stay Intubation Other

Describe:

Birth Weight:

Family History:

Environmental Allergies	Yes	No	If Yes Who?
Asthma	Yes	No	If Yes Who?
Ear Problems	Yes	No	If Yes Who?

Other:

Have siblings been seen in the office? Yes No Name:

Family Pharmacy: Phone number:

Signature: ______________________________________

PARENT/GUARDIAN PLEASE SIGN **RELATION** **DATE**