CAMINO
EAR, NOSE & THROAT CLINIC

Patient Information

Patient Name _____ Date _____

Address _____

City, State, Zip _____ Sex ☐ Male ☐ Female

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Communication Preference ☐ E-Mail ☐ Home Phone ☐ Mobile Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Employer _____

Insurance Information

Primary Insurance Provider _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

Secondary Insurance Provider: _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

Primary Care Physician

Primary Care Physician _____

Address _____

City, State, Zip _____ Phone _____

Referral Information

Referring Physician _____

Address _____

City, State, Zip _____ Authorization # (if needed) _____

Emergency Contact Information

Name and Relationship of Emergency Contact _____

Address _____

City, State, Zip _____ Telephone _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify

Race ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other race ☐ Declined

CAMINO
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Pediatric Patient Health History

Date_____ /_____ /_____

Patient Name _____ DOB _____ Age _____

School _____

Pharmacy Name and Address _____

Medical History/Birth History

Method of delivery? ☐ Normal Vaginal ☐ Cesarean Section

Were there any complications or infections during pregnancy? ☐ No ☐ Yes

If yes, please explain:_____

Was child born premature? ☐ No ☐ Yes If yes, list gestational age _____ weeks

Was child in the NICU? ☐ No ☐ Yes If yes, was child intubated? ☐ No ☐ Yes

Did child pass newborn hearing screening? ☐ No ☐ Yes ☐ Unsure

Was child breastfed? ☐ No ☐ Yes

Please indicate any therapy child is receiving: ☐ PT ☐ OT ☐ Speech ☐ Other _____

Are your child's immunizations up to date? ☐ No ☐ Yes

Have you refused or declined any immunizations? ☐ No ☐ Yes If yes, which one(s)? _____

Does your child have or ever had any of the following conditions? Please check:

☐ Behavior/developmental disorders:
_____

☐ Ear infections. If yes, how many in past 12 months:
_____

☐ Easy bruising/bleeding disorder:
_____

☐ Heart problems:
_____

☐ Stomach or intestinal problems:
_____

☐ Strep throat or tonsillitis. If yes, how many in past 12 months:
_____

☐ ADHD/ADD
☐ Asthma
☐ Bladder/urinary tract infections (UTIs)
☐ Bronchitis/pneumonia
☐ Cancer/leukemia
☐ CMV exposure
☐ Cystic fibrosis
☐ Diabetes
☐ Headache/migraine
☐ Jaundice
☐ Meningitis
☐ Seizures
☐ Thyroid disease
☐ Tuberculosis

Do you think your child hears normally? ☐ No ☐ Yes

Has anyone voiced concerns about your child's speech development? ☐ No ☐ Yes

Please list other medical conditions your child may have:

_____

_____

_____

Previous Surgery

Has your child had any surgeries?

☐ No ☐ Yes (please list below)

Surgery	Date

Medications

Is your child taking any prescribed or over the counter medicines?

☐ No ☐ Yes (please list below)

Medication	Dosage	Reason for taking

Is your child allergic to any medications?

☐ No ☐ Yes (please list below)

Medication	Type of Reaction

Family History

Is there a family history (immediate family only) of medical problems? ☐ No ☐ Yes

- ☐ Hearing loss before age 50
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Problems with anesthesia
- ☐ Stroke
- ☐ Other _____

Social History

Does your child attend day care? ☐ No ☐ Yes

Are there pets in the house? ☐ No ☐ Yes If yes, number/types: _____

Is there smoke exposure? ☐ No ☐ Yes If yes, describe exposure: _____

Who does the child live with? (Include siblings): _____

School grade? _____ List any special schools or classes _____

Number of languages spoken at home: _____

Do the child's siblings have ear infections? ☐ No ☐ Yes

Does the child use a pacifier? ☐ No ☐ Yes Stopped using pacifier at age (if applicable): _____

Does the child have poor academic performance? ☐ No ☐ Yes

Review of Symptoms
Please check only those symptoms your child has developed:

Constitutional:

- ☐ Anxiety
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Weight gain
- ☐ Weight loss

Ear, Nose, Throat:

- ☐ Difficulty swallowing
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Hay fever
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Post nasal drip
- ☐ Ringing in ears
- ☐ Sinus problems

Eye:

- ☐ Blurred vision
- ☐ Double vision

Gastrointestinal:

- ☐ Acid reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Poor appetite
- ☐ Stomach pain
- ☐ Vomiting

Genito-urinary:

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control/wets bed

Musculoskeletal:

- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness

Neurological:

- ☐ Balance problems/dizziness
- ☐ Fainting
- ☐ Memory problems
- ☐ Seizure
- ☐ Tremors

Respiratory:

- ☐ Hoarseness
- ☐ Mouth breathing
- ☐ Oxygen dependence
- ☐ Persistent cough
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Snoring or gasping at night
- ☐ Wheeze/asthma

Skin:

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal