To our new patients:

Welcome to Southwest Idaho Ear Nose and Throat. Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. In order to expedite the check-in process for your appointment, we have included the necessary forms for you to complete in advance.

Please fill out your paperwork completely and bring it with you to your appointment, arriving 15 minutes early. If desired, you may fax your paperwork to our office at **(208) 367-3979** prior to your appointment. Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This includes Medicare and Medicaid as well. If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled. Financially, payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charges.

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family. Thank you for choosing Southwest Idaho Ear Nose and Throat.

CHILD

Patient's Name: ______________________________ D.O.B. ______________

Referring Physician: ______________________________

Name and Location of Pharmacy Used: ______________________________

What is the doctor seeing your child for today? ______________________________

List all current medication including any over the counter (OTC) medications or supplements that your child is taking.

☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines your child cannot take.

☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Does your child have known allergy to any of the following? ☐ NONE

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other ______________________________

Please Describe

Allergies

☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing

☐ Never Done
☐ Skin Blood
☐ Negative
☐ Where Testing Done

Allergy Injections

☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed

____
____
____
____

PAST HEALTH HISTORY

Please indicate any diseases or problems that your child has had or been diagnosed with by a doctor.

☐ No Major Illnesses

Congenital (Birth) Problems
☐ Down's Syndrome
☐ Heart Defect
☐ Prematurity (# of weeks)
☐ Other ________________

Childhood Diseases
☐ Mumps
☐ Measles
☐ Chicken Pox
☐ Other ________________

Cancer
☐ Lung Cancer
☐ Breast Cancer
☐ Throat Cancer
☐ Leukemia
☐ Other ________________

Head & Face
(not incl. brain or nervous s stem)
☐ Tension/Stress Headache
☐ Other ________________

Ears
☐ Chronic or Frequent Infection
☐ Fluid
☐ Hearing Loss
☐ Vertigo
☐ Other ________________

Nose and Sinuses
☐ Chronic Sinusitis
☐ Deviated Septum
☐ Nasal Polyps
☐ Allergies
☐ Other ________________

Mouth and Throat
☐ Chronic Tonsillitis
☐ Cleft Palate
☐ Sleep Apnea
☐ Vocal Polyps
☐ Other ________________

Heart
☐ Atrial Fibrillation
☐ Chest Pain/Angina
☐ Heart Attack
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Pace Maker
☐ Other ________________

Lungs
☐ Asthma
☐ COPD/Emphysema
☐ Cystic Fibrosis
☐ On Oxygen
☐ Other ________________

Digestive
☐ GERD/Reflux
☐ Hepatitis
☐ Diverticulitis
☐ Hemorrhoids
☐ Other ________________

Skin
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Other ________________

Neurologic
☐ Headaches
☐ Stroke
☐ Multiple Sclerosis
☐ Other ________________

Glands and Hormones
☐ Diabetes
☐ Thyroid Problem
☐ Other ________________

Blood Disorder
☐ Low White Blood Cells
☐ Bleeding Disorder
☐ Anemia
☐ Low Platelets
☐ Other ________________

Immune Disorder
☐ Rheumatoid Arthritis
☐ Sjogrens
☐ CREST
☐ HIV
☐ Other ________________

Psychiatric History
☐ Depression
☐ Anxiety
☐ Mania
☐ Schizophrenia
☐ Other ________________

SURGERIES/INJURY

Has your child ever had problems with anesthesia (being put to sleep for surgery)? ☐ Yes ☐ No

Please list any surgeries your child has had.

☐ No Surgery

Name of Operation: ________________________________ Date: ______________

Please list any admissions to a hospital other than the above.

☐ No Hospitalization

Reason for Hospitalization: __________________________ Date: ______________

FAMILY HISTORY

☐ Family History Unknown

Do any of your child's BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia, malignant hypothermia
☐ Hearing Loss after age 20
☐ Hearing Loss before age 20
☐ Heart Problems
☐ Bleeding/Clotting Problems

☐ Cancer
☐ Other Major Health Problems
____
Please Describe
☐ No family history problems known

SOCIAL HISTORY

Marital status of parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Is child adopted? ☐ Yes ☐ No

Names of child's parents:
____
____

Names of child's siblings: ______________________________
____
____

REVIEW OF SYSTEMS/SYMPTOMS

Please indicate any other symptoms that your child has now or has had in the RECENT past.

General
☐ None
☐ Fever
☐ Sleeping Problems
☐ Unintentional Weight Loss

Allergy Symptoms
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin Blood
☐ Negative
☐ Where Testing Done

____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________

____
Please Describe

Facial / Eye Problems
☐ None
☐ Headaches
☐ Facial Pain
☐ Facial Weakness
☐ Vision Changes Not Corrected by Glasses
☐ Other Facial or Eye Problems:

____
Please Describe

Ear Problems
☐ None
☐ Ear Pain
☐ Ear Drainage
☐ Hearing Loss
☐ Dizziness
☐ Ringing in Ears (Tinnitus)
☐ Other Ear Problems:

____
Please Describe

Nose Problems
☐ None
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Bleeding from Nose
☐ Sinus Drainage
☐ Other Nose Problems:

____
Please Describe

Mouth Problems
☐ None
☐ Voice Change / Hoarseness
☐ Loud Snoring
☐ Sore Throat
☐ Trouble Swallowing
☐ Other Mouth Problems:

____
Please Describe

Neck Problems
☐ None
☐ Neck Mass
☐ Other Neck Problems:

____
Please Describe

Heart Problems
☐ None
☐ Chest Pain
☐ Lightheadedness
☐ Other Heart Problems:

____
Please Describe

Lung Problems
☐ None
☐ Frequent Cough
☐ Difficulty Breathing
☐ Other Lung Problems:

____
Please Describe

Stomach / GI Problems
☐ None
☐ Abdominal Pain
☐ Heart Burn / Indigestion
☐ Other Stomach / GI Problems:

____
Please Describe

Urinary or Female Health Problems
☐ None

____
Please Describe

Bone / Muscle Problems
☐ None
☐ Painful Joints
☐ Other Bone / Muscle Problems:

____
Please Describe

Breast or Skin Problems
☐ None

____
Please Describe

Brain or Nerve Problems
☐ None
☐ Change in Smell
☐ Change in Taste
☐ Numbness
☐ Weakness
☐ Other Brain or Nerve Problems:

____
Please Describe

Blood or Lymph Problems
☐ None
☐ Excessive Bleeding
☐ Other Blood or Lymph Problems:

____
Please Describe

Immune Problems
☐ None
☐ Unusual Infections
☐ Other Immune Problems:

____
Please Describe

Other Medical Problems Not Listed ____________________
Cardiologist

☐ ____________________ ____________________
☐ ____________________ ____________________
☐ ____________________ ____________________

Please Describe

Patient Name: ____________________________________ Date of birth: __________________

TESTS AND IMMUNIZATIONS

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64yo, when was your most recent Cer-vical CA screening (pap test)? N/A or date: ________________

2. If you are a female patient between the ages of 42-69yo, when was your most recent Breast CA screening (mammogram)? N/A or date: _________________

3. If you are a patient between the ages of 50-75yo, when was your most recent Colorectal CA screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date: _______________

4. If you are a patient 65yo or older, when was your most recent pneumonia vaccination administered? N/A or date: _________________

5. If you are a patient 6 months and older, when was your most recent influenza immuniza-tion administered? N/A or date: __________________

Patient Signature: _______________________________________

Date: ______________________