SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

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. To expedite the check-in process for your appointment, we have included in this packet the necessary forms for you to complete in advance.

To ensure a timely check-in process:

- ✓ Please fill out the paperwork completely, bring it with you to your appointment and arrive 15 minutes early.
- ✓ If desired, you may fax your paperwork to our office at (208) 813-1929 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.
- ✓ Payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charge.

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.

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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 a 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 Syndrome
☐ Heart Defect
☐ Prematurity (# of weeks)
☐ Other _____

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

Cancer
☐ Lung Cancer
☐ Breast Cancer
☐ Throat Cancer
☐ Leukemia
☐ Other _____

Head and Face
(not incl. brain or nervous system)
☐ 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
☐ Sjögren's
☐ 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 Hyperthermia
☐ 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

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

Are the child's vaccinations up to date? N/A or date: _____

Other Medical/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

Parent or Legal Guardian Signature: _____ Date: _____