# CARL L FALCONE, MD, PC

## Ear, Nose & Throat Clinic
## Pediatric Medical History Form

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***Patient Name*** _____ ***DOB***_____

(First) (M) (Last)

Name of your child's pediatrician or family doctor: _____Clinic_____

Is your child in good health? Yes ☐ No ☐ If no, please explain_____

_____

Does your child have any current or past medical problems? (Examples: hearing, lung, urinary tract, blood, immune system, etc.)

No ☐ Yes ☐ If yes, please explain_____

_____

Does your child have a specific named syndrome: No ☐ Yes ☐ If yes, please explain_____

Was there a problem during your child's pregnancy, labor and/or delivery? No ☐ Yes ☐ If yes, please explain_____

_____

Child's Height: _____ Child Weight: _____

Previous hospitalization(s)? No ☐ Yes ☐ If yes, please list _____

Previous Surgery? No ☐ Yes ☐ If yes, please list _____

Current Medications: No ☐ Yes ☐ Please list _____

_____

***ALLERGIES:*** Medication? No ☐ Yes ☐ Please list _____

Hay fever, dust, etc? No ☐ Yes ☐ Please list_____

Foods? No ☐ Yes ☐ Please list _____

Is there a family history of unusual or severe diseases or bleeding problems? No ☐ Yes ☐ If, yes, please explain_____

_____

Is your child in daycare? No ☐ Yes ☐ If yes, your child in a day care with (please check one):

☐ More than 10 children ☐ Less than 10 children

Are there any pets in the home? No ☐ Yes ☐ Please list_____

Is there any other information you would like to share about your child? No ☐ Yes ☐ If yes, please explain_____

_____

_____

_____

***Pharmacy Choice***_____

***Signature of the person completing this form***:_____

***Your relationship with the child/patient:*** _____***Date***_____