

**Toledo Clinic ENT**  
**Pediatric History & Physical**  
**Oliver H. Jenkins, M.D.**  
**Christopher B. Perry, D.O.**

Please Fill Out Both Sides of Form

Name: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Parent/Guardian (minors only) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Onset of Symptoms: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

**Patient History**

Do you have:

If yes, please describe:

Do you have:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please describe:
ADD/ADHD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Food Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seasonal allergies/hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ear infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hearing problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sinus problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Snoring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Strep throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Tonsillitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bleeding tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bronchitis/Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diabetes/Hypoglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Eczema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Lung problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seizures/convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Yeast or fungal infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Complications with surgery or anesthesia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Immunizations up to date	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Exposed to tobacco smoke If yes, who, how much	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	When _____ What Kind _____

Current Medications? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Over the Counter/Herbal Medications: \_\_\_\_\_

**Surgical History**

Type of Surgery	Year of Surgery

**Family history:**

If yes, please indicate relationship to patient:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bleeding tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ear infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ear surgeries	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hearing problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seasonal allergies/hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Other problems/conditions the physician needs to be aware of:

\_\_\_\_\_

Reviewed by \_\_\_\_\_ (staff) Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ (physician) Date \_\_\_\_\_