FORT STREET ENT – PEDIATRIC REGISTRATION FORM

Patient Name: _____ Birth Date: _____ (m/d/yy)

Email: _____ Family Doctor: _____

Allergies :

Penicillin ☐ Dust mites ☐
Environmental ☐ Erythromycin ☐
Cats/Dogs ☐ Adhesive ☐
Pollen ☐ IV Contrast ☐
Latex ☐ Other : _____

Medications (please list):

_____
_____
_____

Medical History

Birth: ☐ Vaginal ☐ C-Section
Complications _____
Immunizations up to date: ☐ Yes ☐ No Details _____
Milestones met: ☐ Yes ☐ No Details _____

Relevant Family History (please describe):

_____

_____

_____

Height:_____
Weight:_____

Surgical History (please describe):

Any difficulties with previous anesthetics: _____

Parent/Caregiver name(s):_____

Do you give consent to send information regarding your EAR, NOSE and THROAT condition to other health care professionals when requested? YES☐ NO ☐ If **YES**, please sign:

X _____