Kearny County Hospital

Ear, Nose, Throat, and Allergy Clinic

Child Intake Form

Julie A Munson, DO - Tiana Bishop, PA-C - Ginnie Rincones, APRN

Child's Name: _____ DOB: _____

Mother Name: _____ Father Name: _____

☐ Biological ☐ Adopted ☐ Foster/Placement

☐ If the child is adopted, in foster care, or placed with you, you must have the appropriate legal documentation.

Referring Provider: _____ Primary Provider: _____

What town does your child live in? _____

Why is your child being seen today? _____

Pharmacy Preference: _____

Past Medical History: _____

☐ Prematurity/Complications at Birth	☐ Asthma	☐ Allergies	☐ Autism
☐ Genetic Anomalies/Down Syndrome	☐ Accidents	☐ Cleft Palate	☐ Ear Infections
☐ Head/Neck/Facial Trauma	☐ GI Disease	☐ Hearing Loss	☐ Heart Disease
☐ Pneumonia	☐ Reactive Airway	☐ RSV	☐ Tonsillitis
☐ Speech Delay	☐ Other: _____		

Past Surgical History:

☐ None

☐ Ears ☐ Tonsils/Adenoids ☐ Dental ☐ Circumcision ☐ Fractures

☐ Other: _____

Hospitalizations: (With Dates if Known) _____

Food/Medication Allergies: _____

Current Medications (Prescription & OTC): _____

Social History:

Did your child pass the hearing test at birth? ☐ Yes ☐ No

PLEASE TURN OVER AND COMPLETE THE BACK

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Who lives in the home with your Child? _____

Does your child go to daycare? ☐ Yes ☐ No School? ☐ Yes ☐ No Grade:____

Are your child's immunizations up to date? ☐ Yes ☐ No

Does anyone in the family, home or daycare smoke? ☐ Yes ☐ No

Family History:

Mother (Age/Health): _____

Father (Age/Health): _____

Siblings (Health): _____

What has your child experienced in the last 2 weeks?

☐ Hearing Loss	☐ Earache	☐ Ear Drainage	☐ Asthma	☐ Fever
☐ Cough	☐ Sore Throat	☐ Nose Bleeds	☐ Nasal Congestion	☐ Allergies
☐ Rash	☐ Difficulty Swallowing	☐ Speech Problems		

☐ Other: _____