



Patient Demographics



Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ Gender: ☐ M ☐ F

Email Address: _____ Preferred Language: _____

Race: ☐ African American/Black ☐ Native Hawaiian or Pacific Islander Ethnicity: ☐ Hispanic
☐ American Indian or Alaskan Native ☐ White ☐ Non-Hispanic
☐ Asian ☐ Declined

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Primary Care Physician: _____ Physician Phone: (____)____-____

Referring Physician: _____ Referring Physician Phone: (____)____-____

Pharmacy: _____ Pharmacy Phone: (____)____-____

Additional providers to receive reports:

Physician: _____ Physician Phone: (____)____-____

Who has legal custody/guardianship of the patient?

☐ Parents ☐ Grandparent/Other Relative (specify): _____

☐ Mother Only ☐ Foster Parent: _____

☐ Father Only ☐ State Custody/Other (specify): _____

Parent's Information

Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ Relationship to Child: _____

Address: _____ City: _____ State: _____ Zip: _____
(if different from child)

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Place of Employment: _____ Occupation: _____ Work Phone: (____)____-____

Parent's Information

Last Name: _____ First: _____ Middle: _____

DOB: ____/____/____ Relationship to Child: _____

Address: _____ City: _____ State: _____ Zip: _____
(if different from child)

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Place of Employment: _____ Occupation: _____ Work Phone: (____)____-____

Emergency Contacts (please provide 2)

Name: _____ Phone: (____)____-____ Relationship: _____

Name: _____ Phone: (____)____-____ Relationship: _____



Patient Medical History



Last Name: _____ First: _____ Middle: _____ DOB: ____/____/____

Reason for Visit: _____

Has the child had any recent imaging related to reason for visit? ☐ Yes ☐ No Where? _____ When? _____

Birth History:

How many weeks was your child at birth? _____ Weeks

Where was your child born? _____

Please list any complications with pregnancy or delivery: _____

Did your child stay in the NICU? ☐ Yes ☐ No If yes, how long was the NICU stay? _____

Did your child pass the newborn hearing screening? ☐ Yes ☐ No

If no, which ear(s)? ☐ Right ☐ Left ☐ Both

Medical History

Additional space is provided at the end of the document for any information that does not fit below.

Please list past medical problems or diagnoses. Check here if NONE ☐

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Please list any specialist physicians caring for your child. Check here if NONE ☐

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

Please list any hospitalizations. Check here if NONE ☐

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____

Surgical History

Please list all surgical procedures your child has had. Check here if NONE ☐

Date of Procedure ____/____/____ Procedure: _____

Date of Procedure ____/____/____ Procedure: _____

Date of Procedure ____/____/____ Procedure: _____

Any complications with anesthesia? ☐ Yes ☐ No

Complications: _____

Any other surgical complications? ☐ Yes ☐ No

Complications: _____

Medications

Please list all current medications your child is taking. Check here if NONE ☐

Medication Name: _____ Dose: _____ Prescriber: _____

Medication Name: _____ Dose: _____ Prescriber: _____

Medication Name: _____ Dose: _____ Prescriber: _____

Medication Name: _____ Dose: _____ Prescriber: _____

Medication Name: _____ Dose: _____ Prescriber: _____

Medication Name: _____ Dose: _____ Prescriber: _____

Please list any medication allergies/adverse reactions. Check here if NONE KNOWN ☐

Medication Name: _____ Reaction: _____

Allergen: _____ Reaction: _____

[illegible]

Social History

Is/was the patient breastfed? ☐ Yes ☐ No
Does the patient currently use a bottle? ☐ Yes ☐ No
Does the patient currently use a pacifier ☐ Yes ☐ No
Is the patient exposed to cigarette smoke? ☐ Yes ☐ No
Is the patient in school/preschool/daycare? ☐ Yes ☐ No

School/Daycare Facility: _____

Grade/Level: _____

Has the patient missed school due to symptoms? ☐ Yes ☐ No

Is the patient receiving special school support (i.e. Special Ed, Therapy)? ☐ Yes ☐ No

Please list all school therapies/services: _____

Does the patient receive private therapy services (i.e. speech, physical, occupational therapy)? ☐ Yes ☐ No

Please list any private therapy services:

Therapy Provided: _____ Facility: _____

Therapy Provided: _____ Facility: _____

Therapy Provided: _____ Facility: _____

Please list all members living in the child's household (i.e. mother, father, etc.).

Last Name: _____ First: _____ Age: _____ Relationship: _____

Last Name: _____ First: _____ Age: _____ Relationship: _____

Last Name: _____ First: _____ Age: _____ Relationship: _____

Last Name: _____ First: _____ Age: _____ Relationship: _____

Last Name: _____ First: _____ Age: _____ Relationship: _____

Last Name: _____ First: _____ Age: _____ Relationship: _____

Please list any and all Pets: _____

Review of Systems

Please answer Yes or No if the patient has ever had any of the health issues below. If yes, please explain in the space provided.

Ear/Nose/Throat? ☐ Yes ☐ No _____

Cardiovascular? ☐ Yes ☐ No _____

Respiratory? ☐ Yes ☐ No _____

Gastrointestinal? ☐ Yes ☐ No _____

Genitourinary? ☐ Yes ☐ No _____

Musculoskeletal? ☐ Yes ☐ No _____

Skin? ☐ Yes ☐ No _____

Neurological? ☐ Yes ☐ No _____

Psychiatric/Behavioral? ☐ Yes ☐ No _____

Endocrinological? ☐ Yes ☐ No _____

Hematological/Lymphatic? ☐ Yes ☐ No _____

Allergic/Immunologic? ☐ Yes ☐ No _____

Please list any additional medical problems, medications, allergies, etc. here. Additionally, if there is anything else your doctor should know about the patient, please provide that additional information in this area.

PRENATAL AND BIRTH HISTORY

List drugs/medication taken during pregnancy:

Birth weight: _____ lbs _____ oz

Delivery was by:

- ☐ Caesarian
☐ Vaginal
☐ Breech

Check all that pertain to your baby:

- ☐ Mother had rubella (measles), cytomegalovirus (CMV), herpes, toxoplasmosis, or syphilis during pregnancy
- ☐ Baby required a blood transfusion shortly after birth due to hyperbilirubinemia (i.e. jaundice)
- ☐ Baby required mechanical ventilation (breathing machine) for 5 or more days after birth
- ☐ Baby was in NICU after birth and required ECMO (forced oxygen into tissue)
- ☐ Baby had an infection after birth such as meningitis, mumps, or measles
- ☐ Baby was hospitalized after birth and required IV antibiotics or chemotherapy
- ☐ Baby experienced head trauma (i.e., a serious fall causing a concussion or skull fracture)
- ☐ Baby has been diagnosed with a particular syndrome or disorder (i.e., Down Syndrome, cleft palate)
- ☐ Baby has had or currently has an infection or fluid behind the eardrum
- ☐ Baby had Anoxia (blue color) after birth
- ☐ Baby was jaundiced (yellow color) after birth requiring treatment:
☒ phototherapy ☐ direct sunlight ☐ heating blanket
- ☐ Baby had swallowing problems after birth
- ☐ Baby had difficulty sucking after birth

HEARING HISTORY

Check all that apply:

- ☐ The baby startles to loud sounds (throws arms out)
- ☐ The baby is soothed by parent or caregiver voice



Ear, Nose and Throat Specialists

Karin S. Hotchkiss, M.D., F.A.C.S.
Joshua R. Mitchell, M.D.
Kristine D. Brentz, M.D.
Yamilet M. Tirado, M.D.
Jennifer H. Millett, A.P.R.N.
Jenna M. Gilboy, A.P.R.N.
Samanta Roopnarain, A.P.R.N.
Cecilia G. Camacho, Au.D.
Katie K. Pawlowski, Au.D.,

Permission to Treat

It is best that children are brought for treatment by a parent or legal guardian. However, there may be times when someone other than you take care of your child. This form allows the person you choose to seek treatment and sign consent for your child when you are unable to come with the child. The person you name must be 18 years of age or older.

I, (parent / legal guardian) _____, cannot accompany my child (child name) _____ to their appointment. Therefore, I give permission to the following individual(s) to seek treatment and provide consent.

Name:

Relationship to Child:

☐ this form will remain in effect until revoked

☐ this form is **valid only** during the following time frame:

Effective Date: _____ Expiration Date: _____

Parent / Legal Guardian Signature: _____ Date: _____