PLEASE COMPLETE FORMS BELOW

NOTE: PLEASE **DO NOT** FILL IN YOUR CHILD'S NAME OR DATE OF BIRTH PRIOR TO ARRIVING AT APPOINTMENT

Patient Information

_____ _____

Gender: M or F

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

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

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

Additional providers to receive reports:

Physician:_____Physician Phone: (____)____-_____

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):_____**

Mother's Information

Last Name:_____First:_____ Age: _____

Address:_____ City:_____State:____Zip: _____
(if different from child)

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

Occupation:_____Work Phone: (____)____-_____

Father's Information

Last Name:_____First:_____ Age:_____

Address:_____ City:_____State:____Zip: _____
(if different from child)

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

Occupation:_____Work Phone: (____)____-_____

Emergency Contacts (please provide 2)

Name:_____Phone: (____)____-_____Relationship: _____

Name:_____Phone: (____)____-_____Relationship: _____

PATIENT HISTORY

Date of Visit: _____ _____/_____

Reason for Visit:

_____

_____

_____

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

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: _____

Allergies:

Please list any medication allergies/adverse reactions. Check here if NONE KNOWN ☐
Medication Name:_____ Reaction:_____
Medication Name:_____ Reaction:_____
Medication Name:_____ Reaction:_____
Medication Name:_____ Reaction:_____

Please list any food/environmental allergies. Check here if NONE KNOWN ☐
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____

'amily History: **Please mark any family member ever having the problem/disorder listed below, otherwise mark N/A.**

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	N/A
Allergy											
Anesthesia Problem											
Asthma											
Bleeding Disorder											
Breast Cancer											
Cancer											
Diabetes											
Depression											
Ear Infections											
Ear Tubes											
Hearing Loss											
High Blood Pressure											
High Cholesterol											
Heart Disease											
Kidney Disease											
Snoring/ Sleep Apnea											
Tonsil Infections											
Sinus Infections											
Migraines											
Thyroid Disease											
Hydrocephalus											

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 (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.).
First Name:_____ Relationship:_____Age:_____
First Name:_____ Relationship:_____ Age:_____
First Name:_____ Relationship:_____ Age:_____
First Name:_____ Relationship:_____ Age:_____
First Name:_____ Relationship:_____ Age:_____
First Name:_____ Relationship:_____ Age:_____

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 anitbiotics 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