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: _____

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: _____

Family History:

Please mark any family member ever having the problem/disorder listed below.

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	N/A
Allergy											
Anesthesia Problem											
Asthma											
Bleeding Disorder											
Cancer											
Depression											
Diabetes											
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 (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 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

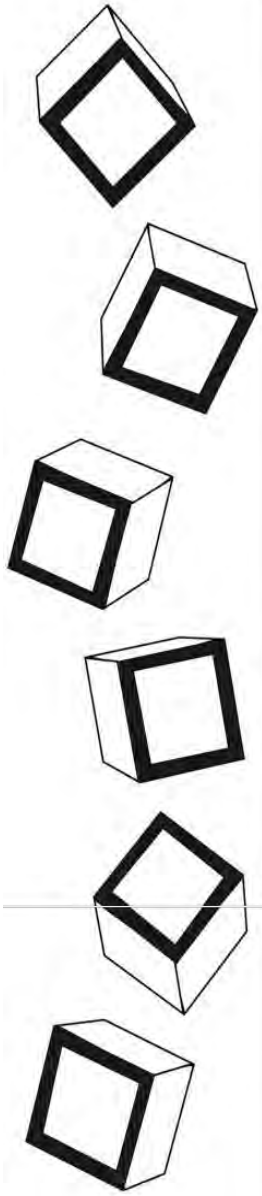
HEARING HISTORY

Check all that apply:

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

TAMPA CHILDREN'S ENT
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 that 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: _____