

# Tucson Ear, Nose & Throat, P.C.

Stanley W. Coulthard, M.D.      Joe M. Huerta, M.D.  
Robert B. Cravens, Jr., M.D.      William R. LaMear, M.D.  
Robert L. Dean, M.D.      Keith C. Soderberg, M.D.

## Please Fill Out Regarding Your Child's General Health

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Primary care physician: \_\_\_\_\_

CHIEF COMPLAINT (Primary reason for visit):

\_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Who is the child's guardian (able to make medical decisions) if it's not the parents listed above?

\_\_\_\_\_

### SIBLINGS:

	Name	Age	Medical Problems
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

### PATIENT:

	Medication	Dose	Frequency	Reason for medicine
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____

Allergies to Medications (Include LATEX allergy) \_\_\_\_\_ Type of reaction \_\_\_\_\_

1) \_\_\_\_\_

2) \_\_\_\_\_

Is your child up to date on shots?    Y    N    If no, explain: \_\_\_\_\_

Is your child around anyone with a chronic illness that may affect his/her health?    Y    N

If yes, please explain: \_\_\_\_\_

**Birth History of Child and Mother (check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Born vaginally      | <input type="checkbox"/> Born by C-Section    | <input type="checkbox"/> Spent time in ICU |
| <input type="checkbox"/> Had yellow jaundice | <input type="checkbox"/> Went home in 1-3days | <input type="checkbox"/> Mom had infection |
| <input type="checkbox"/> Child had infection | <input type="checkbox"/> Alcohol use by mom   | <input type="checkbox"/> Drug use by mom   |

**FAMILY HISTORY:**

Check all of the following diseases that your child's siblings, parents, aunts, uncles, or grandparents have or had:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hearing loss besides old age                                      | <input type="checkbox"/> SIDS           | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Hay fever            |
| <input type="checkbox"/> Tuberculosis (TB)   | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Alcoholism  | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Any Known syndrome (e.g. Down's syndrome, Neurofibromatosis, etc) |   |   |

If yes, please explain \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Check all that apply regarding your child's past medical history

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Hearing loss   |
| <input type="checkbox"/> Wears glasses                 | <input type="checkbox"/> Balance problem | <input type="checkbox"/> Chicken Pox    |
| <input type="checkbox"/> High Cholesterol              | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Speech delay   |
| <input type="checkbox"/> Delayed in meeting milestones | <input type="checkbox"/> Blood in urine  | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Learning Disability           | <input type="checkbox"/> ADD or ADHD     | <input type="checkbox"/> Bedwetting     |

Other: \_\_\_\_\_

**Please list surgeries and hospitalizations**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

---

Parent Signature \_\_\_\_\_ Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the above information with the patient's guardian

---

Physician Signature \_\_\_\_\_ Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_