

PEDIATRIC PATIENT INFORMATION

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Parent Name: _____ **Pediatrician:** _____

Home Address: _____

city _____ State _____ zip code _____

Home # _____ **Work/Cell #** _____

E-mail address: _____ **Referral Source:** _____

What brought you in today? _____

Primary Language Spoken at home: _____

Do you now, or have you ever had, any concerns about your child's hearing? _____

Does your child have a permanent hearing loss that you are aware of? _____

Please describe the hearing loss/ cause: _____

Does any member of your family, or your child's teacher, ever expressed concern about your child's hearing? _____

Hearing History

Does your child respond to sound consistently? _____

Do you feel you need to repeat things for your child in order to be understood? _____

Does your child say "what?" or "huh?" frequently? _____

Do you need to raise your voice in order for your child to respond? _____

Does your child like to sit close to the television, or does he/she turn up the volume? _____

Does your child appear to have difficulty understanding speech in background noise? _____

Has your child had a formal hearing test by an audiologist? (not just a screening at the doctor's office or in school)? _____

Medical History

High Fevers/Serious Illnesses _____

Ear Infections (If yes, how many) _____

Hospitalizations/Surgeries _____

Medications _____

Family history of hearing loss _____

Social History

Does your child interact well with others his/her own age? _____

Behavior Problems? _____

School _____ **School Grade** _____

Name of your child's teacher/ Educational Audiologist _____
