THE CENTER FOR audiology

PEDIATRIC HISTORY FORM

(Please Print)

Today's Date:			
Patient's last name:	First:	Middle:	
Preferred name:	Social Security #:		Birth date:

Sex: ☐ M ☐ F	Street address:	City:	State:	Zip:

E-mail:	Child's pediatrician:
Home Phone: ( )	Alternate Phone: ( )

In case of emergency who should be notified?	Phone number: ( )	Relationship to patient:

Whom may we thank for referring you? ☐ Family ☐ Friend _________________ ☐ Dr.____________________________
☐Online ☐ Other: ____________________________

Insurance Information

(Please give your insurance card to the receptionist)

Primary Insurance company:	ID #	Group #
Secondary Insurance company:	ID #	Group #

Audiologic History

Are you concerned about your child's hearing?	☐ Yes ☐ No	If yes, please explain:
Did your child pass his/her newborn hearing screen?	☐ Yes ☐ No	If no, please describe results:
Is there a family history of hearing loss?	☐ Yes ☐ No	Has your child had a history of ear infections? ☐ Yes ☐ No
Has your child been exposed to loud sounds (e.g. heavy machinery, hunting, etc.)	☐ Yes ☐ No	Has your child had ear tubes placed? ☐ Yes ☐ No
Are you concerned regarding your child's speech or language development?	☐ Yes ☐ No	Is your child currently receiving Speech/language therapy? ☐ Yes ☐ No
Is your child currently receiving occupational/physical therapy?	☐ Yes ☐ No	Does your child wear hearing aids? ☐ Yes ☐ No Manufacturer/Model: ______________________ Serial # Right: ______________________ Serial # Left: ______________________

Has your child had or currently have any of the following:

Adenoidectomy	☐ Yes ☐ No	Age _____	Heart problems	☐ Yes ☐ No	Age _____
Asthma	☐ Yes ☐ No	Age _____	Headaches	☐ Yes ☐ No	Age _____
Allergies	☐ Yes ☐ No	Age _____	Head injury	☐ Yes ☐ No	Age _____
Cancer	☐ Yes ☐ No	Age _____	Jaundice	☐ Yes ☐ No	Age _____
Chemotherapy	☐ Yes ☐ No	Age _____	Kidney problems	☐ Yes ☐ No	Age _____
CMV	☐ Yes ☐ No	Age _____	Meningitis	☐ Yes ☐ No	Age _____
Encephalitis	☐ Yes ☐ No	Age _____	Seizures	☐ Yes ☐ No	
Genetic disorder	☐ Yes ☐ No		Any other medical condition:		

Where would you like a copy of today's report sent?

Any additional comments you would like the audiologist to know:

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