Referral:_____

Pediatric Patient Information

Date:_____

Name:_____DOB:_____ Age:_____

Address: _____City/Stae/Zip_____

Home Phone: _____ Cell Phone:_____

Work Phone: _____ Email address: _____

School District: _____ Grade: _____

Parent/ Guardian: _____Phone #_____

Primary Care Doctor: _____ Address_____

Phone # _____Primary Insurance/ID# _____

PLEASE HAVE A MEDICATION LIST

Do you think/know he/she has a hearing loss?	YES / No	
Has he/she ever had your hearing tested?	YES / NO	When?_____
Difficulty following multi-step instructions?	YES / NO	
How many people live in the child's household?	_____	
ANY surgery/trauma to head or neck?	YES / NO	Describe _____
Has he/she been exposed to loud noises?	YES / NO	Describe _____
Do you experience any acute/chronic dizziness?	YES / NO	
Family history of childhood hearing loss?	YES / NO	
Does the child have siblings?	YES / NO	
New born hearing screening	PASS/ FAIL	

PLEASE CHECK ALL THAT APPLY

_____Difficulty Following Conversations	_____Jaundice at birth	_____Premature birth
_____ADD/ADHD	_____504 plan/IEP	_____Ear infections
_____TMJ Disorder	_____Vision Problems	_____Cancer
_____Depression/Anxiety	_____low birth weight	_____Chemo / Radiation
_____Head Injury	_____Diabetes Type (1)___ or (2)___	_____ Allergies
_____Epilepsy/ Seizures	_____Migraine	_____Chicken pox/shingles

Please list any medical conditions or history I should be aware of: _____