PEDIATRIC HISTORY FORM *(please print)*

Today's Date:					
Patient's last name:	First:		Middle:		
Preferred name:	Social Security #:		Birth date and Age:		
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:		
Primary Care Physician:					
Whom may we thank for referring you? ☐ Family ☐ Friend ☐ Newspaper ☐ Online ☐ Dr._____ ☐ 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 Age ____
Genetic disorder ☐ Yes ☐ No Age ____	Any other medical condition:
Parent/Guardian Signature: _____	