

**OLYMPIC HEARING CENTER
CHILDREN (5 to 13)**

(Please Print)

NAME: _____ DATE: _____ / _____ / _____
Month Day Year

BIRTHDATE: _____ / _____ / _____ AGE: _____ MALE FEMALE
Month Day Year

Parent(s)/Caregiver(s) Names: _____

Others living in the house: _____

Primary Care Physician: _____

Referring Physician: _____

School Attending: _____ Grade _____

MEDICAL/AUDIOLOGICAL INFORMATION

Please circle YES or NO and comment if appropriate

GENERAL HEALTH:

Significant illness	YES	NO	_____
Ear Surgery	YES	NO	_____
History of ear infections	YES	NO	_____
Ear pain or drainage	YES	NO	_____
Allergies	YES	NO	_____
Balance Problems	YES	NO	_____
Trauma or injury	YES	NO	_____
Previous Hearing Test	YES	NO	_____
Sleeping Problem(s)	YES	NO	_____
Behavior Problem	YES	NO	_____
Learning Problem(s)	YES	NO	_____
Medications (Please list)	YES	NO	_____

FAMILIAL HISTORY

Hearing loss	YES	NO	_____
Speech/Language Problems	YES	NO	_____
Illness/Disease	YES	NO	_____

CURRENT CONCERNS:
