

**OLYMPIC HEARING CENTER
CHILDREN UNDER 5 PATIENT DATA**

(Please Print)

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

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

PARENT(S)/GUARDIAN(S) NAME: _____

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

BIRTH HISTORY:

| | | | |
|-----------------------------|-----|----|-------|
| Abnormal pregnancy/delivery | YES | NO | _____ |
| Failed Newborn Screening | YES | NO | _____ |

GENERAL HEALTH:

| | | | |
|------------------------------|-----|----|-------|
| Not Developing appropriately | YES | NO | _____ |
| Significant illness | YES | NO | _____ |
| Trauma/Accident(s) | YES | NO | _____ |
| Eating/Swallowing Problem | YES | NO | _____ |
| Allergies | YES | NO | _____ |
| Balance Problems | YES | NO | _____ |
| History of ear infections | YES | NO | _____ |
| Ear pain or drainage | 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:
