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

BIRTH HISTORY:

Abnormal pregnancy/delivery	YES	NO	____________
Failed Newborn Screening	YES	NO	____________

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	____________
Recent Behavior Changes	YES	NO	____________
Learning Difficulties	YES	NO	____________
Recent changes in grades	YES	NO	____________

FAMILIAL HISTORY:

Hearing loss	YES	NO	____________
Speech/Language Problems	YES	NO	____________

MEDICATIONS: ______________________________

CURRENT CONCERNS:

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