

**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 _____
Sleeping Problem(s) YES NO _____
Behavior Problems YES NO _____
Learning Difficulties YES NO _____
Previous Hearing Test YES NO _____

FAMILIAL HISTORY

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

MEDICATIONS: _____

CURRENT CONCERNS:

