1) Print the form. 2) Complete it. 3) Bring it with you to your appointment.

McLean, VA: (703) 942-8110
Lansdowne, VA: (703)723-9672
Rockville, MD: (301) 468-7670
www.HearingAidDoctors.com

Pediatric Hearing Health Report

Confidential Information for patients less than 18 years old

Date:____

Patient's Name:___________________________________Referred by:_______________________

Address:_______________________________________City/State/Zip Code:__________________

Gender: ☐ Male ☐ Female DOB:____________Age:_______Pediatrician:______________________

Reason for Referral:____

Parents' Names:____

Home Phone:________________Cell Phone:_________________Email: _____________________

Was pregnancy/delivery of patient normal? (Check one) ☐ Yes ☐ No

If "NO", please explain:____

Primary Insurance:___________________Insured Name:____________________Insured DOB:________

Secondary Insurance:_________________Insured Name:____________________Insured DOB:________

How did you hear about us? ☐ Mail ☐ Phone ☐ Newspaper ☐ Yellow Pages ☐ Television ☐ Web ☐ Physician ☐ Referral

Hearing Health History

Was the patient in the NICU? ☐ Yes ☐ No — If so, for how long: ____________

Is/was there a deformity of the ear? ☐ Yes ☐ No — Cleft Lip / Palate ☐ Yes ☐ No

Did patient pass his/her newborn hearing screening? ☐ Yes ☐ No — For both ears? ☐ Yes ☐ No

Has the patient experienced chronic ear infections? ☐ Yes ☐ — If so, when was the last one? _______

Has the patient ever had tubes placed in the ears? ☐ Yes ☐ No — If so, when/which ear? __________

Has the patient had any ear surgeries? ☐ Yes ☐ No — If so, when? ________________

Is there a family history of hearing loss? ☐ Yes ☐ No

Has the child previously had his/her hearing testing? ☐ Yes ☐ No — If yes, If “YES,” when and where?______

____

Amplification History

Does the child have a known hearing loss? ☐ Yes ☐ No _____________________________________

Has the child previously worn/currently wear hearing aids? _____Left ______Right _____Both ______________________

Are there any concerns regarding the patient’s speech/language development? If “YES,” is the child receiving therapy/services?: __________

____

Has there been any history of developmental delays? If “YES,” is the child receiving therapy/services?: __________________

What concerns you most about your hearing/understanding and communication difficulties? ____________________

____

Please describe any other significant medical history: ___________________________________