hearbright

Hearbright, an Audiology Corporation

Agility Hearing Care & Devices

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PEDIATRIC MEDICAL HISTORY

Patient's Last Name:	**Patient's First Name:**
Patient's Date of Birth:	**Age:**
Referred By: (Physician's Name)	
Signature for release of medical information to above physician: X	**Date:**
Print your name and relationship to patient:	

What is the reason for the child's evaluation today? _____

Please mark, circle, or briefly explain your main concern regarding the child's ears or hearing:

Yes/No	Description	Specify	Comment
Yes/No	Are there concerns regarding hearing loss?	(circle one or both) Right Ear Left Ear	
Yes/No	Any problems during inutero, at birth or following delivery of this child:		
Yes/No	Did the child have jaundice?	Severity?	
Yes/No	Did the child pass the newborn hearing screening?	Were multiple attempts made?	
Yes/No	Concerns regarding speech and language development?		
Yes/No	Has the child met normal developmental milestones (i.e. sitting, crawling, and walking)		
Yes/No	History of ear infections?	(circle one or both) Right Ear Left Ear	When was the most recent infection?
Yes/No	Has the child ever had a prolonged high fever (>100 degrees)?		
Yes/No	Family History of Hearing Loss or Ear Problems?	Hearing loss during later years in life Ear Surgery Deafness (circle one)	Mother Father Siblings Other
Yes/No	Ear Surgery	Right Ear or Left Ear	When? Type?
Yes/No	History of Hearing Aid Use?	(circle one or both) Right Ear Left Ear	When?