Welcome to Hanover Audiology

Please tell us a little about your child….

Patient's Name: _____ Gender: Male ____ Female ____
Address: _____ Date of Birth: ____/____/_____
City: _____ State: ____ Zip: _____ Telephone: (___)_____ *cell or home*
Child lives with: Both Parents _____ Mother _____ Father _____ Other _____

Mother's Name: _____ Father's Name: _____
Telephone: (___)_____ *cell or home* Telephone: (___)_____ *cell or home*

Primary Insurance Carrier: _____ Telephone: (____)_____
Name of Policy Holder: _____ DOB of Policy Holder: ____/____/____

Alternate Contact (In case of Emergency)

Name: _____ Relationship: _____
Address: _____ Telephone: (____)_____ *cell or home*
City: _____ State: ____ Zip: _____ Email: _____

Names and ages of any other children living at home:

_____(_____) _____(_____)
_____(_____) _____(_____)

Names and address of Child's School, Preschool or Child Care Setting: _____
_____

Allergies (please list): _____
_____
Current medications: _____
Referring MD: _____ Telephone: (____) _____
Primary Care MD: _____ Telephone: (____) _____
May we send information to your child's doctor? (YES) or (NO)

PURPOSE OF TODAY's VISIT

_____
_____
_____

Family Medical History

Does anyone in your family have any of the following?
Allergies _____ Asthma _____ Hearing Loss _____ Heart Disease _____ Diabetes _____ HBP _____
Does anyone in your household smoke? Yes ____ No ____

Hearing History

Do you have any concerns about your child's hearing? Yes____ No____
If yes, briefly explain: _____

_____

Does your child consistently respond to your voice? Yes____ No____

Does your child respond to loud noises? Yes____ No____
If yes, how: _____

_____

When sound is present or someone is speaking, does your child search to locate or turn to look for the source of the sound (such as when his/her name is called)? Yes____ No ____
Does your child enjoy listening to music? Yes____ No____
Has your child's hearing ever been tested before? Yes____ No____
If yes, please list by whom, when, and results: _____

_____

Does your child wear hearing aid(s)? Yes____ No____
If yes, when was your child first fit: _____ Audiologist: _____
Does your child use an auditory FM System? Yes___ No____ Unsure ____
Does your child receive preferential classroom seating/special academic concessions? Yes ___ No____ Unsure ____
Does your child have and IEP or 5O4 plan? Yes___ No____ Unsure ____

Pregnancy and Birth History

Mode of Delivery: Vaginal ____ C-section ____ Birth Weight: ____lb/____oz
Complications during pregnancy? Yes____ No____
Complications during labor? Yes____ No____
Complications during delivery? Yes____ No____
If yes, explain:_____

_____

_____

Following birth, did your child have any of the following*? (Please check all that apply*)

Infections ___	Require an incubator ___	Feeding problems ___
Surgery ___	Breathing difficulties ___	Failed hearing screening ___
Jaundice ___	Extended hospital stay ___	Head, neck or ear abnormalities ___

If yes to any of the above, explain: _____

_____

_____

_____

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**