CLEARCHOICE HEARING AND BALANCE

Referral:______________________

Pediatric Patient Information

Date:______________________

Name:____DOB:________________________ Age:______________

Address:__ ____ City/State/Zip____

Home Phone:______________________________________ CellPhone:____

Work Phone: ______________________________________ Email address: ____

School District: ____________________________________ Grade: ____

Parent/ Guardian___________________________________ Primary Care Doctor:____

Address____ Phone # ____

Primary Insurance/ID# ______________________________ Secondary Insurance/ ID # ____________________________________

PLEASE HAVE A MEDICATION LIST

Do you think/know he/she has hearing loss? YES / NO

Has he/she ever had their hearing tested? YES / NO When?____

Does he/she have tinnitus/ringing in their ears? YES / NO

Difficulty following multi-step instructions? YES / NO

How many people live in the child's household? _______

Has he/she been exposed to loud noises? YES / NO Describe ____

Does he/she experience any acute/chronic dizziness? YES / NO

Family history of hearing loss? YES / NO

Does your child have siblings? YES / NO

Newborn hearing screening YES / NO

PLEASE CHECK ALL THAT APPLY

_____Difficulty following conversations	______Jaundice at birth	________Premature Birth
______ADD/ADHD	______504 plan/IEP	________Ear Infections
______Jaw or neck issues	______Vision Problems	________Cancer
______Depression/Anxiety	______low birth weight	________Chemotherapy/ Radiation
______Head Injury	______Diabetes Type (1)___ or (2)___	_______ Allergies
______Epilepsy/ Seizures	_______Migraine	_______ Chicken pox/shingles

Please list any medical conditions or history I should be aware of: ____

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