Today's Date: _____

Hearing Care Center

11110 Medical Campus Road, Suite 128
Hagerstown, MD 21742
Phone: 301-714-4390

1. **Demographic Information:**
   Child's name: _____ DOB: ___/___/___ Age: _____ Gender: _____
   Parent's Names: _____ Phone number: _____
   Referring Provider: _____

2. **Statement of Problem:**
   Do you think your child has difficulty hearing? Y N
   If yes, when did you first notice? _____

3. **Birth History:**
   Y N Was the pregnancy full term?
   Y N Any complications during delivery? If yes, describe: _____
   Y N Did your child have a newborn hearing screening at birth? If yes, PASS or FAIL?

4. **Health History**
   Y N Does your child have a history of ear infections?
   If yes, how many? _____ When was the last? _____
   Y N Any previous ear surgeries? If yes, describe: _____
   Y N Does your child take any medications regularly? If yes, what? _____
   Y N Has your child had a fever of 103° or higher? If so, describe: _____

   Has your child ever been diagnosed with any of the following? (Please circle)
   Measles Mumps Chicken Pox Seizures Whooping Cough Flu
   Allergies Sinusitis Vision Loss Meningitis Attention Deficit Disorder
   Other _____

5. **Developmental History**
   Y N Any ear abnormalities? If yes, describe: _____
   Y N Have you noticed any developmental problems?
   If yes, describe: _____
   Y N Any difficulties with speech and language?
   If yes, describe: _____

6. **Family History**
   Y N Family history of hearing loss? If yes, who? _____
   Y N Siblings with speech difficulties? If yes, describe: _____

Signature of Parent/Guardian: _____ Relationship: _____
Today's Date: _____