CLEAR CHOICE
AUDIOLOGY, LLC.

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Pediatric Registration:

Patient's Name: _____ Birthdate: _____ Sex: _____
First M.I. Last

Address: _____ Parent/Guardian SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

Family Physician: _____ Referred Physician: _____

History: (Circle/Check answers below)

Have you had your child's hearing tested before? ___ Yes ___ No
If yes, where? _____ Results? _____

Does your child have a hearing loss? ___ Yes ___ No ___ Unsure (If yes, Right Left Both)
How long? ___Recently (within 90 days) ___ Less than 1 year ___ Over 1 year ___ 5+ years

At what age did you first suspect hearing loss? _____ Wearing hearing aids? _____

Has your child experienced any cold or flu symptoms within the last month? ___ Yes ___ No (Cold / Flu)

Have ringing or noises in the ears? ___ Yes ___ No (If yes, Right Left Both)

Have frequent ear infections? ___ Yes ___ No Ear surgery? ___ Yes ___ No

Have a family history of hearing loss? ___ Yes ___ No If yes, relationship to child _____

Have age appropriate speech/language? ___ Yes ___ No Age appropriate motor development: _____

Have a serious illness or physical injury? ___ Yes ___ No If yes, explain: _____

Have any behavioral disorders? ___ Yes ___ No If yes, explain: _____

Have any handicaps? ___ Yes ___ No If yes, explain: _____

NAS/Prenatal Opiod or other exposure ___ Yes ___ No If yes, explain: _____

Have any noisy hobbies? (ie. hunting, band, MP3 players) ___ Yes ___ No
If yes, please explain: _____

Any birth complications? ___ Low birth weight ___ Jaundice (yellowing) ___ Anoxia (Oxygen) _____Other

Does your child respond well to environmental sounds and speech of others? ___ Yes ___ No
If no, please explain: _____

If school age, how would you describe your child's school performance? _____

Comments: _____

Parent/guardian signature: X_____ Date: _____