**Pediatric form**

Please complete pertinent information - some questions may not be applicable to patient

## PERSONAL INFORMATION

NAME:____________________________________D.O.B:________________Gender: **M** **F**

Name of Parent/Guardian: ____________________________________________________________

Relationship to Patient: _____________________________________________________________

ADDRESS:________________________________________________________________

________________________________________________________________________________

TEL. #: (Home)______________________________(Alternate)____________________________

FAMILY PHYSICIAN:_____________________________________________________________

Release to send report? _____Yes ______ No Consent to administer tests/treatment ____Y ______N

OTOLARYNGOLOGIST (ENT):_____________________________________________________

## INSURANCE

OHIP: _________________________________________

THIRD PARTY: Company name:_______________________ Policy #: ___________________

## MEDICAL HISTORY - pediatric

**Please describe briefly the purpose of your visit: ______________________**

**_________________________________________________________________**

**Briefly explain your concerns (if any):_______________________________**

**_________________________________________________________________**

| | | |
|---|---|---|
| Are there any parental concerns regarding patient's hearing? | Yes | No |
| Is the patient performing well academically? | Yes | No |
| Is the patient tugging on ears and/or complaining of ear pain?<br>If 'yes' - Which ear? **Right Left Both** | Yes | No |
| Does the patient suffer from chronic ear infections? | Yes | No |
| Does the patient have discharge/drainage from ear(s)?<br>If 'yes': Which ear? **Right Left Both** | Yes | No |
| Has the patient had ear surgery?<br>If 'yes': Briefly describe_________________________________ | Yes | No |
| Were there any prenatal complications? | Yes | No |
| Were there any complications during delivery? | Yes | No |
| Does the patient have any known congenital anomalies?<br>If 'yes', briefly describe: _________________________________ | Yes | No |
| Did the patient pass the newborn hearing screening at the hospital? | Yes | No |
| Is there a family history of hearing impairment? | Yes | No |
| Is the patient attaining appropriate developmental milestones? | Yes | No |
| Is the patient attaining appropriate speech development? | Yes | No |
| Has the patient ever suffered a head injury with internal bleeding? | Yes | No |
| Is the patient diabetic? | Yes | No |

Is the patient taking any medication? Yes No
Please list:______________________________________________

Does the patient have any allergies? Yes No
If 'yes': Please list: ______________________________________

Does the patient currently wear hearing aids? Yes No

**How did you *hear* about us (please circle)?**

Friend/Family – Name: ____________________________
Doctor Referral Newspaper Mail Drop
Yellow-pages Website The Drive Windsor Life

# Thank you!

Comments are welcomed:______________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________