Submit by Email Print Form

Potomac Audiology

One Central Plaza
11300 Rockville Pike Suite 105
Rockville MD 20852
240-477-1010

Child History Form (Please print)

Today's Date: _____

Child's Name: _____

Birthdate ____/____/____ **Age: _____** **Gender:** ☐ Female ☐ Male

Contact Information:

Parent/Caregiver's Name: _____
Telephone (H) _____ Telephone (C) _____
Email address: _____

Home Address: _____
_____
_____

Hearing History

1. Explain **concerns** you have about your child's hearing abilities:
   _____
   _____
   _____

2. Did your child have a **newborn** hearing screening? ☐ Yes ☐ No ☐ Don't know

3. Has your child's **hearing been tested** previously? ☐ Yes ☐ No ☐ Don't know
   If yes, please identify the date of the test and the results (if known):
   _____
   _____

4. Does anyone in your **family** have a hearing loss that started before the age of 30? ☐ Yes ☐ No ☐ Don't know
   If yes, please explain: _____

5. Does your child **consistently respond** to your voice? ☐ Yes ☐ No ☐ Not sure

6. Does your child/infant **startle** to loud noises? ☐ Yes ☐ No ☐ Not sure

7. Does your child have **trouble hearing at school**? ☐ Yes ☐ No ☐ Not sure

8. Does your child have any **speech and language** difficulties?
   ☐ Yes ☐ No ☐ Not sure If yes, please explain: _____
_____

9. Does your child use **hearing aids** and/or any assistive listening devices?
   ☐ Yes ☐ No If yes, please explain: _____ _____
   _____
   _____

Medical History

10. Were there any **complications** at birth? ☐ Yes ☐ No ☐ Don't know
    If yes, please explain: _____
    _____
11. Does your child have ongoing **medical issues**? Has he/she been diagnosed with any medical condition(s)? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
12. Please check if your child has any of the following:
    Meningitis ☐ Allergies ☐ Kidney problems ☐ Measles ☐
    Mumps ☐ Vision problems ☐ Movement problems ☐
13. Has your child had **ear infections**? ☐ Yes ☐ No
    If yes, please describe: _____
14. Has your child had **ear surgery** (to include ear tubes)? ☐ Yes ☐ No
    If yes, please describe: _____
15. Does your child lose their **balance** or fall easily? ☐ Yes ☐ No ☐ Not sure

16. Is your child taking any **medication**(s)? ☐ Yes ☐ No
    If yes, please describe: _____

Would you like a **copy of our findings** sent to your child's primary care physician?

☐ Yes ☐ No

If yes, please provide the name and address:

_____

_____

_____

Insurance Information

Primary Insurance:	Policy Holder: Relationship to patient:
ID Number:	Group Number:
Secondary Insurance:	Policy Holder: Relationship to patient:
ID Number:	Group Number: