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**PEDIATRIC CASE HISTORY FORM**

**PLEASE FILL OUT THE BOTH SIDES**

**SECTION I**

**CHILD NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M/F (circle one) DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(First, Middle Initial, Last)*

**ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ST\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT OR GUARDIAN NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How was your child referred to this office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Insurance(s) Do You Have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the beneficiary?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is His/Her DOB?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the name of your child’s primary care physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want a copy of your child’s hearing test sent to the physician? YES\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_

List any major health conditions your child may have\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications your child is taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were developmental milestones reached appropriately? YES\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If No, explain below

**SECTION II:**

Do you have any concerns about your child’s hearing? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_ If Yes, please explain below.

Has your child had any ear infections? Yes\_\_\_\_\_\_ No\_\_\_\_\_ If yes, how many and when was the last one?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any ringing in the ears? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Has your child had a sudden hearing loss in one or both ears? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Does your child have any dizziness or vertigo? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Does your child have any ear pain? Yes\_\_\_\_\_ No\_\_\_\_\_\_

Is there any family history of hearing loss? Yes\_\_\_\_ No\_\_\_\_\_\_

Has your child had exposure to loud sounds or noise? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Has your child had any ear surgeries? Yes\_\_\_\_\_ No\_\_\_\_\_\_

Are there any other concerns about your child’s hearing that you would like to discuss with the audiologist today?

**SECTION III:**

**Please read the following statement:**

I hereby acknowledge being shown the Notice of Patient’s Privacy Practice of Sonora Hearing Care, LLC**. ( See notice under forms).** I understand that I may request a copy of this notice if I choose.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Parent or Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_