Hearing & Balance Associates
Experience Life Hearing Every Moment

1818 Miccosukee Commons Drive, Tallahassee, FL 32308
Ph.: (850)553-4327 | fax: (850)877-3084
info@hbatallahassee.com | www.hbatallahassee.com

LEON COUNTY SCHOOL HEARING EVALUATION

PATIENT HISTORY

☐ Male ☐ Female *(Please write legibly)*

Name		Date of Birth (mm/dd/yyyy)	Age
Street Name	City	State	ZIP Code
Accompanied by:		Relationship	
Home Phone		Cell Phone	
E-mail Address	Pediatrician/ Primary Care Physician		Provider:
Mother/Guardian name		Occupation	
Employers Name & Address			
Business Phone #		Is it OK to call at work:	
Father/Guardian name		Occupation	
Employers Name & Address			
Business Phone #		Is it OK to call at work:	
Primary reason for this appointment			
Emergency Contact:	Relationship	Phone Number	

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss health information, send reports, and schedule future appointments: _____

_____

Authorization for Treatment and Procedures

I hereby agree to and give consent to be treated by Hearing & Balance Associates of NW Florida

HIPPA Acknowledgement

By signing below, I acknowledge that I have had access to Hearing & Balance Associates of NW Florida's Notice of Privacy Practices.

The above information is accurate to the best of my knowledge.

_____

Printed name of parent/guardian

_____ _____

Parent/Guardian Signature Date

Hearing & Balance Associates
Experience Life Hearing Every Moment

1818 Miccosukee Commons Drive, Tallahassee, FL 32308
Ph.: (850)553-4327 | fax: (850)877-3084
info@hbatallahassee.com | www.hbatallahassee.com

PEDIATRIC HEARING HEALTH HISTORY

Patient Name:	Date of Birth:	Age:
Address:	City/St/Zip:	
Pediatrician/Primary Care Physician:	Phone #: H	

Family History

Were parents relative before marriage Yes No
Family history of kidney disease Yes No
Family history of thyroid problems Yes No
Family history of progressive blindness Yes No
Family history of previous stillbirths or miscarriages Yes No
Family history of hearing loss Yes No
Another affected child in family Yes No

Maternal Factors

Drugs (including antibiotics) Yes No
Specify _____
Exposure to chemicals Yes No
Specify _____
Amniocentesis Yes No
Rh immunoglobulin given/Rh of ABO incompatible Yes No
Maternal illness during pregnancy Yes No
Specify _____
Bleeding Yes No
Anemia Yes No
Diabetes Yes No
Toxemia Yes No
Paternal illness during pregnancy Yes No
Specify _____
During pregnancy, mother exposed to:
Measles Yes No
Mumps Yes No
Chickenpox Yes No
German Measles Yes No
During pregnancy, mother diagnosed with:
Syphilis Yes No
Herpes virus Yes No
Influenza Yes No
Cytomegalovirus (CMV) Yes No
Toxoplasmosis Yes No
Other
Specify _____
_____
_____

Delivery/Labor

Full-term pregnancy Yes No
Labor induced Yes No
Labor less than 3 hr Yes No
Labor less than 24 hr Yes No

Infant/Newborn Factors

Small Birth Weight (< kg/k lb.) Yes No
Birth Weight (lb. /oz.) _____
Apgar low at birth Yes No
In an intensive care unit Yes No
How long (wk.) _____
Breathing problems Yes No
Oxygen given Yes No
How long (wk.) _____
Bilirubin > 15mg/100ml Yes No
Congenital rubella Yes No
Defect of ear, nose, throat Yes No
Specify _____
Congenital heart disease Yes No
Drugs (including antibiotic) Yes No
Specify _____
Exposure to chemicals Yes No
Specify _____
Exposure to radiation Yes No
Specify _____
Paralysis Yes No
Seizures Yes No
Septicemia Yes No

Infant/Childhood

Cognitive impairment Yes No
Eye problems Yes No
Balance/gait/incoordination
Dizziness problems Yes No
Cerebral palsy Yes No
Seizures Yes No
Head trauma/skull Yes No
Ever Hospitalized for:
Meningitis Yes No
Encephalitis Yes No
Measles Yes No
Influenza Yes No
Rubella Yes No
CMV Yes No
Chicken Pox Yes No
Septicemia Yes No
Diabetes Yes No
Sickle Cell Disease Yes No
Other (including conductive Loss)
Specify _____
_____
Cesarean Section Yes No
Other Yes No
Specify _____
_____
_____