Hearing & Balance Associates
Experience Life Hearing Every Moment

Dr. John Koonz, Au.D.
Michael E. McGrew, HIS

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

Patient's Full Name _____ ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Social Security Number (*Optional*):_____

Street Address: _____

City: _____ State: _____ Zip: _____

Accompanied by: _____ Relationship: _____

Email Address: _____

Home Phone: (____) _____ Work Phone: (____) _____Cell Phone: (____) _____

Child's Primary Doctor: _____ Phone #: _____

Mother/Guardian Name: _____ Occupation: _____

Employer's Name and Address: _____

Business Phone: (____) _____ Is it OK to call at work?: ☐ Yes ☐ No

Father/Guardian Name: _____ Occupation: _____

Employer's Name and Address: _____

Business Phone: (____) _____ Is it OK to call at work?: ☐ Yes ☐ No

Primary reason for this appointment: _____

What is the best way to reach you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

How did you hear about our practice? ☐ Physician (Dr. _____) ☐ Yellow book ☐ Radio

☐ Tallahassee Democrat ☐ Our Website ☐ Search Engine ☐ TV ☐ Other: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your 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.

_____ _____

Parent/Guardian Signature **Date**

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PEDIATRIC HEARING HEALTH HISTORY

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **PEDIATRICIAN** _____

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 _____
_____
_____