Complete Hearing

4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | complete-hearing.com

Patient name: _____ Date: _____

Preferred first name: _____ Birthdate: _____ Gender: female / male

Parents / Guardians: _____

Marital status: single / married / divorced / widowed / partner

Pediatrician / Primary Care Physician (PCP):_____

Name of Business & Address of PCP: _____

_____

_____

Which hospital was the patient born at? _____ Patient's birth weight: _____

Which ear(s) did the patient fail in the hospital hearing screening? ☐Right ☐Left ☐Both ☐Unknown

Do you have any hearing concerns for the patient? _____

_____

Does the patient respond to your voice? ☐Yes ☐No

Does the patient respond to loud noise? ☐Yes ☐No

Is there a family history of early onset hearing loss? (Before the age of 30) ☐Yes ☐No

If yes, please state how related & at what age loss occurred: _____

_____

Were there any complications with the pregnancy? (To include but not be limited to: prematurity, prescribed medications, recreational drug use)

_____

_____

During birth, were there any complications? (To include but not be limited to: pre-term labor, umbilical cord issues, emergency C-section)

_____

_____

After birth, were there any complications? (To include but not be limited to: breathing or feeding difficulties, incubator/medication needs, jaundice)

_____

_____

List all medications the patient currently takes & the reason: _____

_____

Any additional concerns / comments: _____

_____

_____