Hill Country Ear, Nose & Throat, P.A.

Otolaryngology
Charles F. Lano, Jr., M.D.,FACS

Audiology
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Pediatric Background Information Sheet

I. Identifying Information

Child's First Name___________________ Middle Initial_____ Last Name_________________

DOB_____________ Sex M/F (circle) SSN________________ Age ______________________

Mother/Guardian First Name_________________ Middle Initial___ Last Name_____________

Father/Guardian First Name_________________ Middle Initial___ Last Name_____________

Address________________________________City/State/Zip____________________________

Area Code & Phone
Home_____________________Work____________________Cell________________________

II. Referral Information

Referred by: ____

Reason for visit: ____

III. Health History

Any illness, infections, or complications during pregnancy? ____________________________
____

Problems during labor or immediately after birth? (serious illness, high fever, medications) ____
____

Full-term pregnancy? (if not, give term?)_____________ Weight at birth _________________

General health of the child _______________________ Birth defects or syndrome? _________

Hospitalizations or surgeries (include reason & date) __________________________________
____

History of ear infections? ______________________ How often? ________________________

IV. Developmental History

What age did your child do the following: Sit alone? _____ Say first word? ______ Walk? _____

Coordination or balance concerns? ____
Behavior concerns? ____

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