Vernick & Gopal, LLC

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Pediatric ENT Evaluation

Date: _____ Reason for today's visit: _____

I. Identifying Information

Child's Name: _____ Date of Birth: _____

Parents/Guardian: _____

Siblings & Ages: _____

Pediatrician: _____ Phone: _____

Send Reports to: _____

II. Health History

List any prenatal, perinatal or postnatal illnesses, infections or complications: _____

_____

Full term pregnancy? _____ Birth weight: _____ General health status: _____

Dates of hospitalizations or surgeries: _____

Multiple ear infections? _____ If yes, how often? _____ Date of last infection: _____

Health concerns: _____

III. Development History

Describe any developmental delays: _____

Describe any genetic abnormalities: _____

Does your child receive speech/language therapy?_____ Occupational therapy?_____Physical therapy?_____

IV. Auditory Information

Do you suspect a hearing loss? _____ If so, why? _____

Does your child wear hearing aids? _____ If so, date initiated: _____

Family members with hearing loss: _____

Primary language spoken in the home: _____

V. Educational Information

Does your child have a 504 Plan or an IEP? _____ If yes, complete the following:

School name: _____

Address: _____

Phone #: _____ Grade: _____ Teacher's Name: _____