Ukiah Hearing Care

Hearing the Happy Sounds of Your Family

◆Patient Information◆

Patient Name: _____ Male____ Female____
Last First M

Street Address_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Birthdate_____ Age_____ Soc. Sec. #_____

Work Phone_____ Employer_____ Occupation_____

Referred By_____

Primary Care Physician_____

Reason For Visit_____

◆Person Responsible For Account◆

Name_____ Soc. Sec. #_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Employer_____

◆Insurance◆

Primary Insurance Coverage

Insurance Co._____

Subscriber_____

Group #_____

SSN# _____

Address_____

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Pediatric Hearing Health History

Patient Name: _____ Gender: ❑ M ❑ F BD: _____ Date: _____

Person Completing Form: _____ Relationship to Patient: _____

I. Primary Concern: Please check **Yes** or **No** and describe below.

Do you feel this child has a hearing loss? _____ ❑ Yes ❑ No

Are you concerned about this child's speech or language development? _____ ❑ Yes ❑ No

Please Describe Concern: _____

_____

_____

II. Prenatal and Birth History:

Length of Pregnancy: _____ Birthweight: _____ APGAR Score: _____

List any medications or drugs (including alcohol) used during pregnancy. _____

_____

Please answer Yes or No for the following, and give details if Yes:

Remarkable Pregnancy _____ ❑ Yes ❑ No

Mother's illness during pregnancy (Herpes, Toxoplasmosis, CMV, Syphilis, Rubella)? _____ ❑ Yes ❑ No

Complicated delivery? _____ ❑ Yes ❑ No

After birth, did this child have:

Breathing difficulties (mechanical ventilation/ECMO)? _____ ❑ Yes ❑ No

Admission to the Intensive Care Unit? _____ ❑ Yes ❑ No

Head, neck or ear abnormalities? _____ ❑ Yes ❑ No

Skin tags or pits near the ears? _____ ❑ Yes ❑ No

Jaundice (high bilirubin)? _____ ❑ Yes ❑ No

Head trauma/defect? _____ ❑ Yes ❑ No

Surgery? _____ ❑ Yes ❑ No

Diagnosis of a neurologic condition? _____ ❑ Yes ❑ No

Diagnosis or suspicion of a syndrome or other unifying disorder? _____ ❑ Yes ❑ No

Vision problems? _____ ❑ Yes ❑ No

Kidney problems? _____ ❑ Yes ❑ No

Details: _____

_____

III. Family History: Please check **Yes** or **No** and describe below.

Family hearing loss before age 40? _____ ❑ Yes ❑ No

Please describe: _____

_____

IV. Communication and Developmental History: Please check **Yes** or **No** and describe below.

Difficulties with pronunciation? _____ ❑ Yes ❑ No

Language development concerns? _____ ❑ Yes ❑ No

Difficulties listening or understanding conversation? _____ ❑ Yes ❑ No

Attention problems at school (if applicable)? _____ ❑ Yes ❑ No

Other developmental delays? _____ ❑ Yes ❑ No

Please describe: _____

_____

V. Hearing and Middle Ear History: Please check **Yes** or **No** and describe below.

Previous hearing test? _____ ❑ Yes ❑ No

Allergies? _____ ❑ Yes ❑ No

Hazardous noise exposures? _____ ❑ Yes ❑ No

Noises in the ears (tinnitus)? _____ ❑ Yes ❑ No

Balance or coordination difficulties? _____ ❑ Yes ❑ No

Please describe: _____

_____

Middle ear health:

Number of ear infections: _____ At what age resolved? _____

P.E. Tubes Placed? _____ ❑ Yes ❑ No

If yes, (by whom and when placed): _____

History of ear pain? _____ ❑ Yes ❑ No

Please list any medications this child is currently taking: _____

General Observations:

Child responds to environmental sounds or voices? _____ ❑ Yes ❑ No

Child startles to loud noises? _____ ❑ Yes ❑ No

Child searches to find the source of sounds? _____ ❑ Yes ❑ No

VI. Physical/General Health Conditions:

List any physical or health conditions or this child has. _____

For Audiologist's Use Only

Otoscopic

	Yes	No
Active drainage observed	❑	❑
Visible Congenital or traumatic deformity	❑	❑
Visible evidence of significant cerumen	❑	❑
Air-bone gap of 15dB (.5, 1, or 2KHz)	❑	❑

Right

Left

Other pertinent information:

_____ Audiologist

Summary

Recommendations