ACADIAN HEARING & SPEECH SERVICES

PEDIATRIC PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
First M. Last

Birthdate_____/_____/_____

Are you concerned about your child's hearing? (please circle) YES NO

Name of hospital where child was born:_____

Did the baby pass the Newborn Hearing Screening at birth? (please circle) YES NO UNSURE

Which ear (if any) failed the Newborn Hearing Screening? RIGHT LEFT BOTH

Yes	No	Please check "yes" or "no" for the following questions
☐	☐	Was child's birth on time? If not, how premature or late?_____
		Baby's birth weight_____
☐	☐	Did the baby require oxygen at birth?
☐	☐	Was the baby blue at birth?
☐	☐	Was the baby jaundiced (yellow) at birth?
☐	☐	Did the mother take any medications/drugs while pregnant? List:_____
☐	☐	Were there any other problems at birth? If so, explain_____

What is the reason for your visit today?_____

Please list any school-related problems_____

Please list all of your child's medications_____

Has your child ever had ear surgery? **YES** **NO**

*If yes, please describe*_____

Has your child ever had any other surgeries? **YES** **NO**

*If yes, please describe*_____

Has your child had a hearing test? **YES** **NO**

*If yes, when?*_____

Please check all that have ever applied to your child:

- ☐ Meningitis
- ☐ Tonsillitis
- ☐ Ear Infections
- ☐ Mumps
- ☐ Syndromes_____
- ☐ Allergies
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Headaches
- ☐ Head Injury
- ☐ Speech Difficulties
- ☐ Vision Difficulties
- ☐ Motor Problems
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Family history of hearing loss
  If so, who?_____
- ☐ Other_____

Today's Date_____/_____/_____