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___________________________