Patient Information Form

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____ Age: _____
Last First MI mo day year

Gender: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referred by: _____ Primary Care Physician: _____

Other specialists involved in care: _____

Primary reason(s) for today's visit: _____

_____

Insurance Information

Person Responsible for Account: _____
Last First MI

Primary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Group Number: _____ ID Number: _____

Secondary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth:_____

Group Number: _____ ID Number:_____

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____ Date: _____

Pediatric Hearing Health History

Patient Name: _____ Gender: M F Age: _____ 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

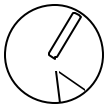
Child searches to find the source of sounds? _____ ❑ Yes ❑ No

VI. Physical/General Health Conditions:

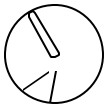
List any physical or health conditions or this child has. _____

For Audiologist's Use Only

Otoscopic



Right



Left

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

Other pertinent information:

_____ Audiologist

Summary

Recommendations

Patient Name: _____
Date of Birth: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Systems History

Ears, Nose, Throat, and Mouth

Ears
- ☐ Hearing loss
- ☐ Consistent ear infections
- ☐ Placement of PE tubes (when? _____)
- ☐ Skin tags or pits near the ears
- ☐ Struggle with hearing in noisy places
- ☐ No concern

Nose
- ☐ Chronic congestion
- ☐ Frequent sinus infections
- ☐ Trouble breathing through nose
- ☐ No concern

Throat
- ☐ Painful swallowing
- ☐ Pain or discomfort after of talking
- ☐ Hoarseness
- ☐ Frequent throat clearing
- ☐ Feeling of something 'stuck' in throat
- ☐ No concern

Mouth
- ☐ Difficulty chewing
- ☐ Coughing frequently while eating
- ☐ Constant dry mouth
- ☐ No concern
- ☐ Other: _____

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Shortness of breath with exertion
- ☐ No concern
- ☐ Other: _____

Psychiatric
- ☐ Anxiety or stress
- ☐ Depression
- ☐ Sleep problems
- ☐ No concern
- ☐ Other; _____

Vision

Acuity
- ☐ Nearsighted
- ☐ Farsighted
- ☐ Astigmatism
- ☐ No concern

Visual Processing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Difficulty tracking
- ☐ Objects moving while trying to focus
- ☐ Dyslexia
- ☐ No concern
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ Apnea/ Dyspnea
- ☐ Shortness of breath
- ☐ Frequent episodes of pneumonia, bronchitis, or other infections
- ☐ Trouble achieving adequate breath support
- ☐ No concern
- ☐ Other: _____

Neurological
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Weakness
- ☐ Tremors
- ☐ Seizures
- ☐ Memory loss
- ☐ Poor attention
- ☐ History or brain injury or concussions
- ☐ No concern
- ☐ Other: _____

Skin
- ☐ Rashes
- ☐ Acne
- ☐ Eczema
- ☐ No concern
- ☐ Other: _____

Musculoskeletal
- ☐ Muscle/ joint pain
- ☐ Back pain
- ☐ Scoliosis
- ☐ No concern
- ☐ Other: _____

Gastrointestinal/ Genitourinary
- ☐ Heartburn or reflux
- ☐ Frequent nausea/ vomiting/ diarrhea
- ☐ Constipation
- ☐ Nighttime urination
- ☐ Kidney problems
- ☐ No concern
- ☐ Other: _____

Allergies
- ☐ Seasonal allergies
- ☐ Food allergies

Details: _____
- ☐ Medication allergies

Details: _____
- ☐ None
- ☐ Other: _____

Motor Development

Fine Motor
- ☐ Poor handwriting
- ☐ Trouble grasping small objects
- ☐ Trouble opening or closing screw-lid containers
- ☐ Trouble coordinating vision with hand movements (i.e. putting a puzzle together)
- ☐ No concern

Gross Motor
- ☐ Trouble balancing
- ☐ Falls often
- ☐ Easily trips over objects
- ☐ No concern
- ☐ Other: _____

Previous Diagnoses

Please check all previous diagnoses.
- ☐ ADD
- ☐ ADHD
- ☐ Autism
- ☐ Asperger's Syndrome
- ☐ Cerebral Palsy
- ☐ Downs Syndrome
- ☐ Mental Retardation
- ☐ OCD
- ☐ No concern
- ☐ Other: _____