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: ______________

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

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: ______________________

____

Kirkland Office 12333 NE 130th Lane, #430 Kirkland, WA 98034 425.899.5050 Fax - 425.899.5054
Bellevue Office 1800 116th Ave NE, #103 Bellevue, WA 98004 425.454.1883 Fax - 425.454.2036
Redmond Office 8301 161st Ave NE, #208 Redmond, WA 98052 425.882.4347 Fax - 425.883.0043

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

Patient Name: ____________________
Date of Birth: ____________________

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: ____________________