



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?
Are you concerned about this child's speech or language development?

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
Mother's illness during pregnancy (Herpes, Toxoplasmosis, CMV, Syphilis, Rubella)?
Complicated delivery?

After birth, did this child have:

Breathing difficulties (mechanical ventilation/ECMO)?
Admission to the Intensive Care Unit?
Head, neck or ear abnormalities?
Skin tags or pits near the ears?
Jaundice (high bilirubin)?
Head trauma/defect?
Surgery?
Diagnosis of a neurologic condition?
Diagnosis or suspicion of a syndrome or other unifying disorder?
Vision problems?
Kidney problems?

Details:

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

Family hearing loss before age 40?

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:**

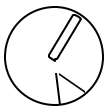
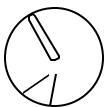
Child responds to environmental sounds or voices? \_\_\_\_\_  Yes  No

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			
		Yes	No
Otoscopic	Active drainage observed	<input type="checkbox"/>	<input type="checkbox"/>
	Visible Congenital or traumatic deformity	<input type="checkbox"/>	<input type="checkbox"/>
	Visible evidence of significant cerumen	<input type="checkbox"/>	<input type="checkbox"/>
	Air-bone gap of 15dB (.5, 1, or 2KHz)	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Other pertinent information:</i>		
 Right	<b>Summary</b>		
 Left			
_____ Audiologist		<b>Recommendations</b>	



Patient Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_

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
Medication allergies
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: \_\_\_\_\_