



PATIENT INFORMATION FORM- CHILD

Patient Name (First, Middle, Last) _____

Name Patient goes by (if different from given name): _____

Date of Birth: _____ Age: _____ Gender: _____

Primary Language: _____

Parent/Guardian Name: _____

Relationship to child: Biological Adoptive Foster Grandparent Step Other: _____

Authorization for treatment must be signed by the custodial parent or guardian before the individual can be seen in their absence.

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Cell Home

Secondary Phone Number: _____ Cell Home

Email Address: _____

School: _____

Family Physician/Clinic Name: _____

Referring Physician/Clinic Name: _____

Emergency Contact & Phone Number: _____

Responsible Party: _____ Responsible Party SSN: _____

Insurance Policy Holder: _____ Date of Birth: _____

Please provide Patient Care Coordinator's with your insurance card(s)

Authorization for Treatment

I consent to treatment for my child from Professional Hearing Services:

Signature of custodial parent/guardian: _____ Date: _____

Relationship to patient: _____

Name: _____ Date of Birth: _____

HEARING HEALTH QUESTIONNAIRE:

What is the child's chief complaint/reason for the visit? _____

Do you feel your child may have hearing loss? Yes or No

Did your child have a traumatic birth? Yes or No If yes, describe: _____

Length of pregnancy: _____

Did the child spend any time in the NICU? Yes or No If yes, for how long? _____

What were the results of your child's hearing screening at birth? Circle one:

Passed both ears Did not pass Did not pass left ear only Did not pass right ear only

Did any of the following occur during pregnancy? (Circle all that apply)

Alcohol Abuse Substance Abuse Smoking German Measles/Rubella
Infections Venereal Disease Maternal Illness Cytomegalovirus (CMV)

Has your child ever taken any of the following medications? (Circle all that apply)

Vancomycin Chemotherapy Gentamycin Streptomycin

Has your child ever had a fever greater than 104°? Yes or No

If yes, how old was your child? _____ How long did it last? _____

Has your child had any of the following? (Circle all that apply)

Ear infections/fluid Draining ear(s) Allergies Tonsillitis Frequent cold/Flu
High fevers Seizures Breathing difficulties Blood transfusion Chicken Pox
Measles Mumps Rubella Cytomegalovirus (CMV) Encephalitis
Meningitis Scarlet fever Pulmonary hypertension Head trauma (hospitalization
required) CHARGE syndrome Down syndrome Cleft lip and/or palate
Small/absent ear(s) Skin tags or pits around the ear(s)

If other, describe: _____

Is there a family history of hearing loss? If yes, please explain: _____

Communication history:

Does your child have difficulty communicating at home?	Yes	Sometimes	No
Does your child have learning difficulties or educational concerns?	Yes	Sometimes	No
Does your child struggle in social situations?	Yes	Sometimes	No
Does your child have speech or language difficulties?	Yes	Sometimes	No
Does your child prefer the TV at a louder than normal?	Yes	Sometimes	No
Does your child feel embarrassed or frustrated in noisy settings?	Yes	Sometimes	No
Does your child have sensitivity to sound?	Yes	Sometimes	No

Does your child currently wear hearing aids? YES NO

Hearing Aid Brand: _____Where/when did you get the hearing aids? _____

If your child is an infant, answer the following:

Does your child respond consistently to sounds?	Yes	Sometimes	No
Does your child turn to find a sound source?	Yes	Sometimes	No
Does your child enjoy listening to music?	Yes	Sometimes	No
Does your child respond to their name?	Yes	Sometimes	No
Does your child startle to loud sounds?	Yes	Sometimes	No

We will send a copy of your test results and/or report to your referring or ordering physician. If you would like any additional physicians and/or other entities to receive a copy of your tests and/or report, please notify our receptionist and complete a records release.