Infant History Questionnaire (0-24 months)

Child's Name ______________________________ Age ______________

Person Completing Form ______________________________ Date ______________

Relationship to Child ______________________________

Primary Care Physician ______________________________

Referring Physician ______________________________

Have we seen you at this office before? ☐ Yes ☐ No

Describe problem or reason for this evaluation ______________________________

Does your child have a hearing impairment? ☐ Yes ☐ No ☐ Unknown

How long have you noticed this problem? ______________________________

Are you concerned about your child's hearing? ☐ Yes ☐ No. If yes, explain ______________________________

____

Describe your concerns (check all that apply)

☐ Failed newborn hearing screening ☐ Right ☐ Left ☐ Both

☐ History of hearing loss in the family (who? ______________________________)

☐ Inconsistent responses to sound

☐ Does not startle to loud sound

☐ Does not respond to their name

☐ Other ______________________________

Birth and Prenatal History

Place of Birth ______________________________

Birth weight ________ lbs ______________ oz Premature? ☐ Yes ☐ No APGAR Score (if known) ______________

Jaundiced? ☐ Yes ☐ No Highest bilirubin #______________ Placed under lights? ☐ Yes ☐ No

Were there any complications during pregnancy or birth? ☐ Yes ☐ No

Describe any pre/post natal problems ______________________________

Length of pregnancy ______________ Length of labor ______________ Birth method ______________

At birth did the baby have the following: (please check)

Anoxia (blue color)	☐ Yes ☐ No	Respiratory distress	☐ Yes ☐ No	Jaundice (yellow color)	☐ Yes ☐ No
Remain in the hospital	☐ Yes ☐ No	Swallowing problems	☐ Yes ☐ No	Sucking problems	☐ Yes ☐ No

Turn Over

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Is your child adopted? ☐ Yes ☐ No If yes, from where? ______________________

Does your child know he/she is adopted? ☐ Yes ☐ No

Do you have a pre-or post natal report or history of the parents? ☐ Yes ☐ No

Has your child's hearing been tested before? ☐ Yes ☐ No

Who? ______________________

When? ______________________

Has your child ever had?

☐ Ear infections? How often? ______________________

☐ Drainage from one or both ears?

☐ Too much wax in the ears?

☐ Ear tubes placed in the eardrums by an ENT physician?

Name of Physician ______________________

Where? ______________________

At what age(s) did treatment occur? ______________________

Has your child been evaluated by the Early Intervention Program? ☐ Yes ☐ No

Was he/she eligible for their services? ☐ Yes ☐ No

Speech & Language

What concerns do you have about your child's speech? ______________________

____

____

Has your child been evaluated by any another medical specialist? ☐ YES ☐ NO Check all that apply:

☐ Pediatric neurologist ☐ Developmental specialist ☐ Chiropractor

☐ Physical therapist ☐ Occupational specialist ☐ Audiologist (elsewhere)

☐ Speech-language Pathologist ☐ Early Intervention Program ☐ Other ______________________

Medical History

Is there any medical diagnosis? (e.g., Down syndrome, cerebral palsy, etc.) ☐ YES ☐ NO

Be specific ______________________

Family History

Is there a family history of hearing loss? ☐ YES ☐ NO

Who ______________________

What was the cause (if known) ______________________

____

WEST COAST
HEARING CLINIC
You should HEAR what you're missing!

Medication Documentation

Patient Name: ______________________________ Date: ______________

Due to new insurance guidelines for audiologists, it is mandatory that we document current medications prior to billing for your services.

If you have a pre-printed list of your medications, completion of this form is not necessary. Please give that list to the receptionist to copy.

Otherwise, please fill out this form and bring it with you to your appointment.

Below, please list each medication you are currently taking and include the following: prescriptions, over-the-counter, herbals and vitamin/mineral/dietary supplements. Thank you!

Medication Name	Dosage	Frequency	Route: Oral, Shots, Dermal, etc.	Dizziness/ Vertigo (office use only)	Hearing Loss (office use only)	Tinnitus (office use only)