

audiology services – patient information

Date: _____ Patient's name: _____ Date of birth: _____

Person filling out this form: _____ Relationship to child: _____

Thank you in advance for this information.

If you have any questions or concerns before your visit, please feel free to call us.

Cook Children's
Medical Center
682-885-7660

Cook Children's
South Rehab Clinic
682-885-4063

Cook Children's
Child Study Center
682-885-2190

Cook Children's
Mansfield Rehab
682-885-2200

Cook Children's
Northeast Rehab
817-347-2955

- Yes No Are you concerned about your child's hearing?
- Yes No Has your child ever had a hearing test?
Where? _____ Results: _____
- Yes No Have a history of ear infections or fluid behind the eardrum?
- Yes No Did your child have a newborn hearing screening?
Results: _____ Where was your child born? _____
- Yes No Were there any difficulties during or immediately after birth?
- Yes No Was your child placed in the neonatal intensive care unit (NICU)?
- Yes No Is there a family history of hearing loss starting in childhood?
- Yes No Are you concerned about your child's speech and language?
- Yes No Is your child in speech therapy? Where: _____
- Yes No Does the child receive any other kind of therapy?
- Yes No Does your child have allergies to medicines/herbal remedies/latex/food?
- Yes No Does your child take any medicines? List: _____
- Yes No Have there been any changes to your child's medical history?
- Yes No Have there been any recent surgeries, hospitalizations or procedures or new medical diagnosis?
- Yes No Has the child been diagnosed with any congenital and/or acquired syndrome or disease? If yes, please explain _____
- Yes No Is the child in school or daycare? What is the school's name? _____
- Yes No Is your child receiving any special education or resources in school?
- Yes No Have you seen any changes in your child's mood or behavior?
- Yes No Does your child wear hearing aids, cochlear implants, or Baha?
- Yes No Does your child use an FM system at school?
- Yes No Does your child have an Ear Nose Throat (ENT) doctor? Who? _____

What would you like to learn from today's appointment? _____

Please list customs, religious beliefs or wishes that we need to know about: _____

During sessions we will give you directions for activities at home. Do you have a favorite way of learning new information? Pictures Writing Demonstration No Preference

**CookChildren's**