Cadence Hearing Services, LLC

Name:

Date of birth:

Date of visit:

What is the nature of your visit? :
How long has this occurred?

Please indicate if your child is experiencing the following:

- ☐ Ear pain
- ☐ Ear drainage
- ☐ Depression
- ☐ Hearing loss
- ☐ Tinnitus (Ringing/Buzzing in ears)
- ☐ Dizziness
- ☐ Anxiety
- ☐ Trauma to the ear/head
- ☐ Ear fullness
- ☐ Occupational noise exposure
- ☐ Social noise exposure
- ☐ Ear surgery
- ☐ Ear wax problem
- ☐ School issues/Reading/Math
- ☐ Past ear infections/tubes
- ☐ Problems at birth, high bilirubin, low birth weight, any milestone delays
- ☐ Not hearing parents/caregivers
- ☐ Concerns for language and or speech development

Prior medical history

Please indicate if there is a family history of hearing loss, tinnitus, vertigo.

List any other issues your child may be having or has had since birth:

Have you ever been treated by another professional for the above?

Office use only:

Tests today:

Reason for the tests:
Otoscopically:

Lynda Wayne, Au.D

DELIVERY AND LABOR FACTORS

Full-term pregnancy	YES	NO	If no, how many weeks early: ________________
Labor was induced	YES	NO	
Labor less than 3 hours	YES	NO	
Labor longer than 24 hours	YES	NO	
Premature membrane rupture	YES	NO	
Bleeding	YES	NO	
Forceps delivery	YES	NO	
Cesarean section (C-section)	YES	NO	
Other unusual events:	YES	NO	If yes, specify: ________________

NEWBORN FACTORS

Birth weight less than 5 pounds	YES	NO	If yes, specify birth weight: ________________
APGAR score low at birth	YES	NO	If yes, APGAR score if known: ________________
Placed in intensive care	YES	NO	If yes, specify how long: ________________
Breathing problems at birth	YES	NO	
Oxygen given at birth	YES	NO	If yes, specify how long: ________________
Bilirubin > 15mg/100ml	YES	NO	
Congenital rubella	YES	NO	
Defects of ear, nose, throat	YES	NO	If yes, specify: ________________
Congenital heart disease	YES	NO	
Drugs given (inc. antibiotics)	YES	NO	If yes, specify: ________________
Exposure to chemicals	YES	NO	If yes, specify: ________________
Paralysis at birth	YES	NO	
Seizures at birth	YES	NO	
Septicemia	YES	NO	

INFANT / CHILDHOOD FACTORS

Eye problems	YES	NO	If yes, specify: ________________		
Balance/gait/dizziness problems	YES	NO	Cerebral palsy	YES	NO
Seizures	YES	NO	Head/skull injury	YES	NO

CHILD EVER HOSPITALIZED FOR / DIAGNOSED WITH / TREATED FOR:

Meningitis	Encephalitis	Measles	Influenza	Cytomegalovirus (CMV)
Chickenpox	Septicemia	Diabetes	Sickle Cell	Rubella

HISTORY OF EAR PROBLEMS

Ear infections: NONE LEFT RIGHT BOTH If yes, specify what ages, how many and how often:

____

When was last ear infection: ________________________________

Ever had "tubes" in ears? NONE LEFT RIGHT BOTH If yes, specify when & how many times:

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