UCSF Medical Center

Date completed: ____________

Pediatric Audiology Intake Form

Form completed by: ________________________

Relationship to patient: _____________________

Reason for Visit

Please describe the reason for your visit to our clinic today.

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History

Please fill out the questions about the patient's hearing and medical history below.

HEARING HISTORY	Yes	No	Comments
Do you have concerns that your child has hearing loss? If yes, why?			
Has your child received a hearing test in the past? If yes, where and when? (please bring a copy)			
Did your child pass their newborn hearing screening?			Birth Hospital: ________________________________
Does anyone in your child's family or extended family have hearing loss?			
Does your child startle to loud sounds or awaken to loud sounds?			
Does your child quiet to speech and/or music?			
Does your child turn to sound or speech?			
Does your child respond to his/her name?			
Does your child follow directions?			
OTOLOGIC HISTORY	**Yes**	**No**	**Comments**
Does your child have a history of ear infections or drainage from the ears?			If yes, how many? When was the most recent episode?
Does your child exhibit any signs of ear pain? (e.g. verbal complaints, irritability, ear tugging)			
Does your child have a history of ear surgery?			If yes, what kind of surgery? (include dates)

DEVELOPMENTAL MILESTONES	Yes	No	Comments
Is your child meeting developmental and motor milestones? If no, please comment on if he/she is receiving therapies or services at this time.			
SPEECH AND LANGUAGE	**Yes**	**No**	**Comments**
Are there concerns with speech and language development?			
Describe expressive language. (e.g. number of spoken words or signs, using sentences or single words)	-----	-----	
Does your child receive speech therapy?			
Intelligibility to an unfamiliar speaker (ability to understand child's words)	**Good**	**Fair**	**Poor**
Receptive language (ability for child to understand when spoken to)	**Good**	**Fair**	**Poor**
OTHER MEDICAL HISTORY	**Yes**	**No**	**Comments**
Any complications during pregnancy or delivery of this child? If yes, please describe.			Born at ____weeks gestation. Birth weight: ____lb, _____oz Complications:
Was the child's birth history remarkable for any of the following? If yes, please describe. ▪ Hospital stay for 5 days or more after birth (NICU) ▪ Extracorporeal membrane oxygenation (ECMO) ▪ Assisted ventilation ▪ IV antibiotics ▪ Loop diuretics ▪ Hyperbilirubinemia or jaundice (i.e. yellow skin)			
Were there any of the following in-utero infections? If yes, please describe. ▪ CMV ▪ Herpes ▪ Rubella ▪ Syphilis ▪ Toxoplasmosis			
Has your child been diagnosed with a syndrome?			

OTHER MEDICAL HISTORY	Yes	No	Comments
Does your child have a history of meningitis?			
Does your child have a history of chemotherapy treatment?			
Do you have concerns about your child's vision?			

SCHOOL AND OTHER PROGRAMS	Comments
School Name	
School Level/Grade	
Academic performance	

OTHER	Comments
Please describe any additional history not covered on this form.	

Interpreter name (if used): ______________________________________

Affiliation: UCSF Agency (e.g. Lan Do & Assoc.) Family/Friend

Language: _____________