

# Pediatric History Questionnaire

## Patient Information

Chart # \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ First  Male  Female Last MI  
Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parents Full Name \_\_\_\_\_ Reason for Appointment \_\_\_\_\_

E-Mail \_\_\_\_\_ E-Statements Yes  No

Enrolled in First Steps?  Yes  No If yes, Service Coordinator: \_\_\_\_\_ County \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Medical History

Did your child have an infection at birth?

- None  Cytomegalovirus  Rubella  Herpes  Syphilis  Toxoplasmosis

Did your child have asphyxia or breathing problems at birth?  Yes  No

Were any blood transfusions given?  Yes  No

Please describe \_\_\_\_\_

Was your baby in an Intensive Care Unit?  Yes  No

Were there any congenital malformations involving the head, neck or ears?  Yes  No

What was your baby's weight? \_\_\_\_\_

Was your baby born prematurely?  Yes  No How many weeks? \_\_\_\_\_

Was your baby treated with any antibiotics?  Yes  No If so, what kind? \_\_\_\_\_

Did your baby ever have Meningitis?  Yes  No If so, at what age? \_\_\_\_\_

Did your baby have elevated bilirubin (jaundice)?  Yes  No

Is there family history of hearing problems in early childhood?  Yes  No

- Mother  Father  Grandmother  Grandfather  Brother  
 Sister  Uncle  Aunt  Cousin  Other

Does your child have any other associated disability?  Yes  No

- Blindness or vision disorder  Cerebral Palsy  Developmental disability  
 Seizure disorder  Down Syndrome  Learning disability  
 Other \_\_\_\_\_

When did you last consult a physician about your child's ears? \_\_\_\_\_

Has your child had any earaches?  Yes  No If so, which ear(s)?  Left  Right  Both

Have their ears been medically treated?  Yes  No If so, which ear(s)?  Left  Right  Both

Is your child receiving any medication?  Yes  No If so, what kind? \_\_\_\_\_

Has your child ever had ear tubes?  Yes  No If so, when? \_\_\_\_\_ By whom? \_\_\_\_\_

Has your child experienced dizziness?  Yes  No If so, which ear(s)?  Left  Right  Both

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## Hearing and Speech History

Do you think your child has a hearing problem?  Yes  No

How old were they when you first noticed a hearing loss? \_\_\_\_\_

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

Does your newborn startle at loud sounds?  Yes  No  N/A

Does your three-month-old stop moving or crying when you call them?  Yes  No  N/A

Does your six-month-old enjoy noise-making toys?  Yes  No  N/A

Does your nine-month-old babble frequently?  Yes  No  N/A

Does your one-year-old respond to simple yes or no commands?  Yes  No  N/A

At what age did your child first babble? \_\_\_\_\_ First word \_\_\_\_\_

Short (2-3 word) sentences \_\_\_\_\_

How many words does your child have in his/her vocabulary? \_\_\_\_\_

How often does your child use speech?  Frequently  Occasionally  Seldom  Never

Is your child's speech clear?  Yes  No  N/A

If school aged, where does your child attend school? \_\_\_\_\_

Do you have any concerns about your child's progress in school?  Yes  No

If so, please explain \_\_\_\_\_

How did you hear about our services?

Doctoral referral  Advertisement  School

Friend  Yellow pages  Previous patient

Other \_\_\_\_\_

Is there any other information about your child that is important for us to know? \_\_\_\_\_

## Authorization for Release of Information

I authorize \_\_\_\_\_ to release any part or all of my records to those persons listed below:

Name	Address
1. _____	_____
2. _____	_____
3. _____	_____

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Adequate parking	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Convenience of appointment times	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Friendly greeting	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Clean and welcoming environment	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor

What can we do to make your next visit more comfortable?

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## Insurance Information

**Please give your insurance information to our front office staff so we can make a copy for our records.**

**\*\*\*\*\*PLEASE READ CAREFULLY AND SIGN BELOW\*\*\*\*\***

- I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

REFUSE TO RELEASE RECORDS, IF SO INITIAL HERE \_\_\_\_\_

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

**I have read and understand all the above information.**

\_\_\_\_\_ A copy of this signature is as valid as the original

\_\_\_\_\_ Date

**PLEASE SIGN HERE** →

Parent or Guardian \_\_\_\_\_

\_\_\_\_\_ Date