New York Speech and Hearing, Inc.
271 Madison Avenue, Ste. 1405
New York, NY 10016
(212) 260-1414

Pediatric Intake Form

Child's Last Name ______________________ **Child's First Name** ______________________

Parent/Guardian Name: ______________________________________ **Relationship:** __________________________

Reason for Visit: ____

Referred By: ____ **Ref Physician's Tel:** ___________________________

Ref Physician's Address: ____

Primary Care Physician: _______________________________ **PC Physician's Tel:** ____________________________

Physician's Address:____

Your Child's Medical History

Medications:

☐ None

____

____

____

Allergies:

☐ None

____

____

____

Hospitalizations/Surgeries:

Year:	Reason:	Reason for hospitalization / TYPE of surgery
______	______________________________________	____
______	______________________________________	____

Your Child's Hearing History

1. Do you now, or have you ever had, any concerns about your child's hearing? _____________
2. Does your child have a permanent hearing loss that you are aware of? _________________

   If yes, please describe the hearing loss (for example: loss in one ear only, can't hear high pitch sounds): _________

   ____
3. Has anyone ever expressed concern about your child's hearing? ______________________
4. Does your child respond to sound consistently? __________________________________
5. Do you feel you need to repeat things for your child in order to be understood? ___________
6. Does your child say "what?" or "huh?" frequently? ________________________________
7. Do you need to raise your voice in order for your child to respond? ____________________
8. Does your child sit close to the television, or does he/she turn up the volume? _________________________

9. Does your child appear to have difficulty understanding speech in background noise? ______________________

10. Has your child had a formal hearing test by an audiologist(not a screening at the doctor's office or in school)? __________

11. Does your child continue to have ear infections? _____________________________________

    If yes, approximately how many does he/she experience each year? __________________

12. Has your child had an ear infection in the last 6 months? _______________________________

13. Has your child ever been treated with antibiotics for an ear infection? _____________________

    If yes, has your child been treated with more than one antibiotic? _____________________

14. Has your doctor ever observed fluid behind your child's eardrums? _______________________

15. Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)? ______

16. Has your child ever received pressure equalizing (ventilating) tubes for chronic ear infections? _______________

    How many sets of tubes?______________________ At what age(s)?___________________

17. Any recent hospitalizations / surgeries? ____

18. Any history of ear disease? ____

19. Family history of hearing loss? ____

20. Additional Comments/Observations: ____

    ____

Family History: Please check if relatives have had:

☐ Hypertension	☐ Anemia	☐ Cancer (type) :	☐ Other:
☐ Stroke	☐ Asthma	______________________	______________________
☐ Heart Disease	☐ Autoimmune Disease	______________________	______________________
☐ Diabetes	☐ Hearing Loss	______________________	______________________

Patient Name: ____ **Date:** ___________________________

Parent/Guardian Signature:____

Parent/Guardian Name:____