Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

AUDIOLOGY INTAKE FORM (PEDIATRIC)

Child's Name:		Date:
Parent's Name:		
Child's Date of Birth:		Age?

Birth Weight:	Number of Weeks Gestation:
Well Baby Nursery:	NICU Nursery:
	If yes, how long?

Who referred you to us?
Reason for today's visit:

Previous Surgeries, Hospitalizations, Illnesses, High Fevers:

Previous Medical Diagnosis *(if any):*

Medications:
Allergies:

Were there any complications during pregnancy &/or delivery? □ Yes □ No

Please Explain:

Did your child pass the newborn hearing screening? □ Yes □ No

If not, which ear did not pass? □ Right □ Left □ Both

Do you have concerns regarding your child's hearing? □ Yes □ No

Please Explain:

Has your child ever had an ear infection or ear surgery? □ Yes □ No

If yes:

When? _____

Which ear? □ Right □ Left □ Both

Has your child reached his/her developmental milestones at appropriate ages (*crawling, walking, babbling, speech, etc.)*? □ Yes □ No

If not, what was delayed? _____

Is there a history of hearing loss in your family other than age related?

□ Yes □ No

If yes, which family member? _____

Cause of hearing loss (*if known*)? _____

What is the primary language spoken in the home? _____

If there are other languages spoken please list: _____

Where does your child go to school? _____

Do you have concerns regarding your child's?

Speech and Language Development	□ Yes	□ No
Physical Development	□ Yes	□ No
Academic Performance	□ Yes	□ No

Is your child receiving?

Speech and Language Therapy	□ Yes	□ No
Physical Therapy	□ Yes	□ No
Occupational Therapy	□ Yes	□ No
Other _____	□ Yes	□ No