Medical Record #: ____________________

Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

Audiology Department
(551) 996-5327

PEDIATRIC QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: ____

Date of Birth: ____________________ Date(s) of Evaluation: ____________________

_______________________________ *Signature of Patient/Parent/Guardian*

_______________________________ *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

Patient Name: ______________________________

Medical Record #: ____________________

PATIENT INFORMATION

Child's First, Middle, Last Name: ______________________________

Date of Birth: ____________________ Age: ____________ Gender: ______________________

Address: ______________________________

City: ______________________________ State: _____ Zip: ___________ County: __________

Primary Language: __________________________ Other Languages: _________________________

Primary concern for this appointment: ______________________________

Who referred your child for this appointment? ______________________________

Current diagnosis of child (list all): ______________________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian (A) Full Name: ______________________________

First *Last* *(Maiden)*

Date of Birth: _________________ Race: ________________ Ethnicity: ______________________

Please Check: Biological [ ] Step [ ] Foster [ ] Adoptive [ ] Other [ ] ________________

Primary Language: ____________________

Phone Number: ____________________ Email: ______________________________

Address ______________________________ City _____________ State _____ Zip ________

[ ] *check here if address is same as patient*

Parent/Guardian (B) Full Name: ______________________________

First *Last* *(Maiden)*

Date of Birth: _________________ Race: ________________ Ethnicity: ______________________

Please Check: Biological [ ] Step [ ] Foster [ ] Adoptive [ ] Other [ ] ________________

Primary Language: ____________________

Phone Number: ____________________ Email: ______________________________

Address ______________________________ City _____________ State _____ Zip ________

[ ] *check here if address is same as patient*

PREGNANCY, BIRTH, & HEALTH HISTORY

Child's Place of Birth: ______________________________ Birth Weight: __________

Was your child born prematurely? NO YES If yes, how many weeks? _________

Were there any complications during pregnancy or birth? ______________________________

Was your child cared for in the NICU/special care nursery? Why? ______________________________

Patient Name: ________________________________

Medical Record #: _____________________

Was a Newborn Hearing Screening completed at birth? ________________ Results: ___________

Does your child have any allergies? Please list: ____

Is your child taking any medications? Please list: ____

AUDIOLOGICAL HISTORY

Do you think your child has a hearing problem? ____

Has your child ever had a hearing screening at the pediatrician's office? _________ Results? _________

Has your child ever had a complete hearing test before? NO YES

Date/Location: ____

Is there a history of middle ear infections/middle ear fluid? _______________________________________

When was the last ear infection? ____

Who has treated your child's ear infections? How? ____

Is there a family history of childhood hearing loss? Please explain*:* __________________________

DEVELOPMENT HISTORY

Do you have concerns regarding…

… your child's speech and language? NO YES: __________________________

… your child's development? NO YES: __________________________

… your child's behavior? NO YES: __________________________

… your child's general health/nutrition? NO YES: __________________________

Does your child receive any services through Early Intervention at home? NO YES

… if yes, what services? ____

Have there been any *recent* changes in your child's behavior/mood? _____________________________

ACADEMIC HISTORY

Current Grade Level: __________ School: ____

Are there any academic concerns/difficulties? If yes, explain: ___________________________________

____

Has your child ever repeated a grade? If yes, which grade? _____________________________________

Does your child receive any special accommodations/therapies at school? NO YES

… If yes, what services? ____

… Does your child have an Individualized Education Plan (IEP) or 504 plan? ________________

Does your child receive any private therapies/tutoring at home? NO YES: ____________________