PATIENT INFORMATION

To Be Completed By The Patient/Parent/Guardian

Patient Name: _____ Date: _____

Sex: M F Date of Birth: _____ Parent/Guardian Name: _____

Parent/Guardian's Telephone #: Home: _____ Work: _____

Pediatrician/Primary Care Dr. Name: _____ Telephone #: _____

Otolaryngolist: _____ Telephone #: _____

Emergency Contact: _____ Relationship: _____ Telephone #: _____

Who do you consider family & who can we include in your care? _____

Who may we share your Medical / Rehabilitation progress with? _____

1. The parent is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign Language ❑ Other: _____ ❑ Interpreter: _____
2. The parent/guardian is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign Language ❑ Other: _____ ❑ Interpreter: _____
3. Does the patient have any religious, cultural or spiritual practices that may alter their case or education?
   ❑ Yes ❑ No Please describe: _____
4. Describe the reason for the patient's visit to the Rehabilitation Department: _____
   _____
5. Does the patient have any special needs and/or nutritional needs or concerns? ❑ Yes ❑ No
   If yes, what are they? _____
6. Does the patient have all of the vaccinations/immunizations for their age? ❑ Yes ❑ No
   If no, why? _____
7. Does the patient have any allergies? ❑ Yes ❑ No If yes, please list: _____
   _____
8. Please list all medications including over the counter medications that the patient is currently taking:
   _____
   _____
9. Does the patient have any pain? ❑ Yes ❑ No If yes, how are you managing the pain: _____
   _____

HEARING HISTORY

1. Do you have concerns about hearing loss? If so, how long? _____
   _____
2. Was the hearing loss sudden or gradual onset? _____
   _____

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3. Is there a family history of hearing loss? If so, who? _____

4. Is there a history of noise exposure *(work related or trauma)*? _____

_____

5. Is there a history of chronic recurrent ear infections? ❑ Yes ❑ No

If yes, were tubes placed: ❑ Yes ❑ No When: _____

BIRTH HISTORY *(For Pediatric Patients & Adults with Complicated Birth History Only)*

Medical Condition	Yes / No	If Yes, List Dates	If any of the answers are "yes", please explain.
Newborn Hearing Screening Prior to Discharge	❑ Yes ❑ No		
Premature Delivery	❑ Yes ❑ No		
Admitted to NICU	❑ Yes ❑ No		
Low Birth Weight *(Less than 200g)*	❑ Yes ❑ No		
Ototoxic Medications	❑ Yes ❑ No		
Ventilator	❑ Yes ❑ No		
Seizures	❑ Yes ❑ No		
Bacterial Meningitis	❑ Yes ❑ No		
Syndrome	❑ Yes ❑ No		
ECMO	❑ Yes ❑ No		

PAST MEDICAL HISTORY *(Please Check All That Apply)*

Medical Condition	Yes / No	If Yes, List Dates of Occurrence	Medical Condition	Yes / No	If Yes, List Dates of Occurrence
Ear Surgery	❑ Yes ❑ No		Ear Infections	❑ Yes ❑ No	
Vertigo (Dizziness)	❑ Yes ❑ No		Tinnitus (Ringing)	❑ Yes ❑ No	
Hearing Aids	❑ Yes ❑ No		Cancer	❑ Yes ❑ No	
Chemotherapy	❑ Yes ❑ No		Meningitis	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No		Vision Loss	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No		Seizures	❑ Yes ❑ No	
Cardiac Problems	❑ Yes ❑ No		Thyroid Disorder	❑ Yes ❑ No	
Toxemia	❑ Yes ❑ No		Measles	❑ Yes ❑ No	
Mumps	❑ Yes ❑ No		Chickenpox	❑ Yes ❑ No	
German Measles	❑ Yes ❑ No		Syphilis	❑ Yes ❑ No	

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EDUCATION INFORMATION - determined by patient and therapist:

1. How does the patient/parent/guardian learn best? ❑ Written ❑ Visual/Demonstration ❑ Verbal
   ❑ Other: _____
2. Highest level of education the parent/guardian has completed: _____
3. Highest level of education the patient has completed: _____

I, the patient, parent or guardian, have provided accurate information to the best of my knowledge and have received a copy of the Outpatient Rehabilitation Patient Orientation Policies and Procedures. I have read and understand them. It is my responsibility to advise the therapist of any unexpected changes in the patient's condition, medication or additional treatments. I will express any concerns I have to the therapist. I acknowledge that I am responsible for the patient's outcome, if I, the parent or guardian, do not comply with the treatment plan. I, the parent or guardian, permit the hospital to disclose privileged health information to the person dropping the child off or picking the child up.

Signature of Patient/Parent/Guardian _____ Date: _____

To be completed by the therapist:

1. ❑ Communication ❑ Community Resources ❑ Diagnosis ❑ Discharge Planning
   ❑ Hearing Aids ❑ Occupation Hazards ❑ Other: _____
   ❑ Amplified Telephone
2. Potential Barriers to Learning are: ❑ Age ❑ Financial ❑ Cognitive ❑ Religious
   ❑ Physical ❑ Level of Education ❑ Communication ❑ Cultural Beliefs/Values ❑ None
3. Psychological Status: ❑ Alert / oriented x _____
4. Cognitive Status:
   Follows: ❑ Multiple steps or ❑ Single commands or ❑ Unable to follow commands
5. Signs and Symptoms of Abuse or Neglect Noted: ❑ Yes ❑ No
   If yes, what action was taken: _____

Signature of Audiologist: _____ Date: _____

PATIENT/LABEL