PATIENT LABEL HERE

JOHNS HOPKINS CHILDREN'S CENTER

Pediatric Otolaryngology New Patient Questionnaire-Infant Hearing Clinic

Department of Otolaryngology Head & Neck Surgery
601 N. Caroline Street, Baltimore, MD 21287, Fax: (410) 955-0035

Patient's Name:_____ Date of Birth: _____

Primary Care Provider:_____ Parent or Guardian name:_____

How were you referred to our clinic?_____

What age was first screen done? □1st day □ 2nd day □other:_____

Result of first screen- right ear: □ pass □ fail left ear: □ pass □ fail □ don't know

Was there second screen? NO YES □ don't know

Result of second screen right ear: □ pass □ fail left ear: □ pass □ fail □ don't know

How was result communicated to you?_____

What was recommended?_____

Do you think you child has hearing loss NO YES

Does your baby stir or waken when there is a loud sound NO YES

Does you baby look in your directions when spoke to NO YES

Anxiety level in regards to hearing loss, how worried are you today about your baby's hearing?

□ Not at all worried □ Somewhat worried □ Moderately worried □ Very worried

How did you find out about our hearing clinic?_____

Have you looked for information on hearing loss? NO YES, Where_____

Birth History

Problems with Pregnancy? NO YES If so, what?_____

During pregnancy, did mom have: Any infections? NO YES *Any illness?* NO YES

Type of Delivery: Vaginal Cesarean Problems with Delivery? NO YES*, What?*____

How many weeks gestation at time of birth ?_____ Birth Weight: _____lbs _____oz

Apgar scores:_____

Was newborn in the NICU? NO YES *If yes, how long?*_____

In NICU Did your baby have:

Breathing tube NO YES
Mechanical ventilation NO YES
CPaP NO YES
Oxygen NO YES
Antibiotics NO YES
Lasix or diuretics NO YES
Bili light for jaundice NO YES
Blood transfusion NO YES
ECMO NO YES

What is Mom's age? _____

What is Mom's race/ethic heritage? _____

What is Dad's age? _____

What is Dad's race/ethic heritage? _____

PLEASE COMPLETE THE OTHER SIDE OF FORM

Medical History

Does your child have any other conditions/illnesses/diagnoses? NO YES
If yes, please tell us what:

Has your child ever been in a hospital overnight? NO YES
If yes, please provide dates and reason:

Has your child ever had surgery (an operation)? NO YES
If yes, please tell us what kind of surgery and when:

Are your child's immunizations up to date? NO YES

Please check if your child is experiencing any of the following:

___Eye or vision problems
___Ear infections/fluid
___Ear pain or drainage
___Hearing loss
___Runny/congested nose
___Sinus infections
___Seasonal or food allergies
___Nosebleeds
___Throat infections
___Snoring
___Dental problems
___Voice changes
___Thyroid problems
___Lymph node swelling
___Mass in neck
___Asthma
___Cough
___Breathing problems
___Pneumonia
___Heart problems
___Weight loss or gain
___Stomach pain
___Diarrhea
___Difficulty swallowing
___Drooling
___Constipation
___Urine/kidney problems
___Bedwetting
___Joint pain or swelling
___Muscle weakness
___Anemia/blood problems
___Bleeding problems
___Seizures
___Headaches
___Rashes or birth marks
___Speech delay
___Problems with sleep
___Behavior problems
___Psychiatric problems
___Fevers
___Fatigue/tiredness

*Please describe any checked items or other problems not listed:*_____

Family History

Are there any blood relatives/family members with:			*If yes, please describe who and what?*		
Problems with bleeding or bruising?	NO	YES	Sudden death-cardiac	NO	YES
Problems with anesthesia/surgery?	NO	YES	Cleft lip or palate	NO	YES
Asthma/Lung problems?	NO	YES	Vision loss	NO	YES
Allergies?	NO	YES	Retinal detachment	NO	YES
Hearing loss?	NO	YES	Neurodegerative disorder	NO	YES
Genetic or inherited disease?	NO	YES	Kidney disease	NO	YES
Thyroid disease	NO	YES	Other ? _____		

Social History

Is your child in day care? NO YES *How many children in daycare room?___*

Who lives at home with child?_____

Are there sibling-brother or sisters? NO YES *If yes, what age?:*_____

Are there smokers at home? NO YES

Are there pets at home? NO YES *If yes, what kind?*_____

Any other concerns or problems you would like us to know about?

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Post clinic questionnaire

Thanks for seeing us today

What was the result of hearing testing today?

Do you have a better understanding of your child's hearing problem?

Anxiety level in regards to hearing loss, how worried are you today about your baby's hearing?

□ Not at all worried □ Somewhat worried □ Moderately worried □ Very worried

Satisfaction with results today

□ Not satisfied □ Somewhat satisfied □ Moderately satisfied □ Completely satisfied

PLEASE COMPLETE THE OTHER SIDE OF FORM