



**Swedish Otolaryngology – Audiology**

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**PEDIATRIC AUDIOLOGY INTAKE FORM**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent(s) name:** \_\_\_\_\_

**I. Main Concern:**

**II. Prenatal history**

Was mother exposed to any infections during pregnancy (ie. CMV, Herpes, rubella, syphilis, toxoplasmosis) ?  yes  no If yes, describe below.

Drugs taken during pregnancy?  yes  no If yes, describe below.

**III. Birth history**

Born on time? If not, gestational age at birth \_\_\_\_\_ Birth weight: \_\_\_\_\_

Passed newborn hearing screening?  yes  no  unsure

Normal Apgar at birth?:  yes  no

NICU stay required?  yes  no How long? \_\_\_\_\_

If yes, did your child require any of the following during NICU stay:

ECMO  yes  no

Ventilation  yes  no

Exposure to ototoxic medications (gentimycin or tobramycin) or loop diuretics (furosemide/Lasix)  yes  no

Hyperbilirubinemia (high bilirubin levels) requiring transfusion?  yes  no

#### IV. Family history

Is there a family history of ear-related or balance-related problems?  yes  no

Permanent, childhood hearing loss in your family?  yes  no If yes, please describe:

Issue:

Relationship:

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#### V. Developmental history

Any speech and/or language concerns?  yes  no If yes, describe below.

Any other developmental concerns or syndromes?  yes  no If yes, describe below.

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#### VI. Physical history

Ear infections  yes  no If yes, describe below (last infection, treatment, etc)

Cranial-facial concerns?  yes  no

High fevers?  yes  no

Head trauma with hospitalization?  yes  no

Bacterial or viral meningitis  yes  no

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