Stony Brook Medicine

STONY BROOK UNIVERSITY MEDICAL CENTER

PEDIATRIC COCHLEAR IMPLANT HISTORY FORM

Ages 2 months-12 years

Date: _____ Name**:** _____ DOB**:** _____
Address: _____City:_____ Zip:_____
Phone (h): _____ (w): _____ (c): _____
E-mail:_____ in the event we are unable to reach you by phone
Primary Insurance: _____ Referral needed? Y N
Secondary insurance: _____
Mother's name: _____ Father's name: _____
Referred by _____
Person completing form □ Parent/Guardian □ Other-Name/Relationship _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
Name	Relationship to patient	Address	phone	fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.
Signature of □ Patient □ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

In order for a complete evaluation to be performed the patient will need to have a recent hearing aid check with the audiologist that dispensed the hearing aids. A print out of the hearing aid performance must be brought to the cochlear implant evaluation.

Does or has your child been seen by the following? If yes please provide the following information. **Bring all test results with you on the day of your initial appointment.**

	Name	Address/Fax	Phone
Audiologist			
Speech Pathologist			
Ear, Nose and Throat			
Aud Verbal Therapist			
Teacher of the Deaf			
Neurologist			
Psychologist			
PT/OT/Other			

Continue on other side

Name: _____ DOB: _____

Birthing History

Hospital _____Length of pregnancy_____Weight_____
Was your child in the intensive care nursery? Y N if yes, how long?_____
Did your infant experience? Y N
_____ Infections/illnesses? _____ Jaundice? Y N if yes, Treatment?_____
Was your infant on a ventilator? Y N _____ Medications?_____
Did he/she pass the hearing screening at birth? Y N Explain:_____

Medical history

Please indicate if your child has had any of the following:

_____Seizures _____ Meningitis _____ Encephalitis
_____Persistent sore throat _____Nasal allergies _____Tonsillitis
_____ Sinusitis _____ Other childhood Illnesses
_____ Head trauma with concussion or skull fracture _____ Chronic conditions/Syndromes

Ear surgeries Y N If yes, specify type and when _____
Current medications: _____Hospitalizations since birth: _____

Developmental/Behavioral History

At what age did your child:

_____ Hold head up _____ Crawl _____ Sit unsupported
_____ Walk _____ Button Clothes _____ Tie Shoes

Does your child exhibit any of the following behaviors?

_____ Clumsiness _____ Temper tantrums _____ Head banging
_____ Hitting _____ Biting _____ Other

Speech/Language Development

At what age did your child:

_____ Begin to babble _____ First word _____Combine words

What is your child's primary mode of communication?_____
Secondary mode if applicable _____
What is your child's preferred language? _____
List all languages spoken in the home in order of use _____
Approximately how many words does your child use regularly? _____
What is your child's average sentence length? _____

Hearing History

At what age was: Hearing loss first suspected _____ Hearing loss identified _____
Hearing aids fit _____ Therapies initiated _____
Cause of hearing loss? _____Was your child born with hearing loss? _____
What degree was the hearing loss at initial diagnosis? _____
Has the hearing loss become worse over time? _____
List the facilities where your child's hearing has been tested _____

Name _____ MRN _____

Describe your child's hearing loss as explained to you by other professionals_____
Does your child currently wear hearing aids? Y N If so answer, Right Left Both ears
Does he/she wear without resistance? Y N Explain _____
How many hours a day? _____
When were the current hearing aids purchased? _____ Where? _____
Hearing aid brand/model _____
Does your child have a history of ear infections? _____
Describe in your own words your child's hearing difficulties _____
_____

Does your child?

	Unaided	Aided
Show reaction to sound	_____	_____
Awaken to loud sound	_____	_____
Respond to speech	_____	_____
Respond to his/her name	_____	_____
Play vocal games/imitate	_____	_____
Hear on the telephone	_____	_____
Discriminate male vs. female voice	_____	_____
Enjoy music or singing	_____	_____
Attempt to locate source of sounds	_____	_____

EDUCATION/SCHOOL
School name/address/phone _____
Teacher's name _____
Number of days/week _____ half/full days _____Number of children in classroom _____
What primary mode of communication is used in the class? _____
Is it a special needs class? _____
Does the teacher use a FM? If so, type _____
List the classes in which your child is mainstreamed with hearing children_____
List therapies your child receives and frequency? _____
List any previous schools attended, dates of attendance and communication mode used
_____
Does your child read? Y N What is his/her reading age? _____

FAMILY/SOCIAL HISTORY
Are there any relatives, on either side, with the following conditions as children? If yes explain. Include the relationship to the child.
Hearing loss Y N _____
Auditory Processing Y N _____
Ear Infections Y N _____
Trouble speaking Y N _____
Learning difficulties Y N _____
List child's siblings and ages _____
Who lives at home? _____
Marital status of parents _____
Do you think your child gets along well with others? _____

Name: _____ DOB: _____

Audiologist comments _____
_____
_____
_____
_____
_____
_____
_____

Audiologist signature _____ID# _____ Date/Time:_____