BETTERLIVING
AUDIOLOGY

Thank You for Taking the Time to Fill Out This Patient Form Prior to Your Visit.
Please follow the below instructions.

1. **Download the PDF Form**
   Please Note: *Do Not Fill Out the Form Prior to Downloading. The Data Will Not Be Saved.*
2. **Fill Out the Form**
3. **Save PDF as Your Name**
4. **Email Completed Form to frontdesk@betterliving.email.**

Julie Bier, Au.D. • Corey Gibeault, Au.D.
Doctors of Audiology

54 West Twin Oaks Terrace, Suite 10 • South Burlington, VT 05403 • P: 802-651-9374 • F: 802-651-9376
135-A Creek Rd • Middlebury, VT 05753 • P: 802-989-7210 • F: 802-989-7348

betterlivingaudiology.com

Welcome to Better Living Audiology

Better Living Audiology is Northern Vermont's premier hearing and balance healthcare provider. Our Audiologists are doctors dedicated to providing the highest level of medically-oriented diagnostic and treatment services for individuals with hearing loss, tinnitus, and balance disorders. We provide state-of-the-art technology and truly professional care, according to your priorities.

Our goal is to provide the highest quality care to all of our patients in a timely and respectful manner. For your first visit, please plan to arrive 15 minutes prior to your appointment.

Please complete the attached forms and bring them to your appointment or email them to **frondesk@betterliving.email** in advance to help us prepare for your appointment.

Also bring your **Photo ID, Insurance Card, and List of Medications.**

We recommended that you bring a spouse or family member to your initial visit for support.

Please call our office if you have any questions or need to reschedule your appointment.

Thank you for choosing Better Living Audiology for your healthcare needs.

Sincerely,

Better Living Audiology Staff and Providers

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Pediatric Case History Form

Child's Name:_____

Phone:_____

Address:_____
Street City State Zip

Date of Birth:_____ Gender: ☐ Male ☐ Female

Primary Language Spoken in the Home:_____ Other languages spoken:_____

Email Address _____

Other children in the family and their ages: _____

Was the child adopted? ☐ Yes ☐ No

If yes, from what country: _____

Age of child when adopted:_____

Child's School:_____ Current Grade:_____

Family Physician:_____ Date last seen:_____

Reason for visit:_____

Reason for today's visit (your concern):_____

Father's Information **Mother's Information**

Full Name_____ DOB:_____ Full Name_____ DOB:_____

Who has legal custody of this child_____
(Name) (Relationship)

_____
(Address) (Phone)

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Birth History

Age of mother during pregnancy:_____years Length of pregnancy:_____weeks

Did the mother experience any complications during pregnancy, labor or delivery, including illnesses, conditions, accidents, etc.: ☐ Yes ☐ No

If yes, please describe:_____

Was labor: ☐ Spontaneous ☐ Induced ☐ Cesarean Length of labor:_____ hours

Did the mother use tobacco or smoke during pregnancy? ☐ Yes ☐ No

If yes, number of cigarettes/uses per day:_____

Did the mother drink alcoholic beverages (more than one drink per week) during pregnancy?: ☐ Yes ☐ No

If yes, what was the frequency and amount consumed:_____

Did the mother use recreational drugs during pregnancy?: ☐ Yes ☐ No

If yes, what drugs and how often:_____

Did the mother take any other medications during pregnancy (other than vitamins)?: ☐ Yes ☐ No

If yes, what drugs and for what condition(s):_____

Child's birth weight:_____

At birth, did the baby suffer from or experience any of the following complications (please check all that apply):

- ❑ Jaundice
- ❑ Breech birth
- ❑ Low birth weight
- ❑ Blue color
- ❑ Breathing/respiratory difficulties
- ❑ Premature birth
- ❑ Low APGAR score
- ❑ Infection of baby or mother
- ❑ Cesarean birth
- ❑ Sucking/swallowing difficulties
- ❑ Induced labor

Did your child pass their Newborn Hearing Screening? ☐ Yes ☐ No

Any other conditions or complications at birth:_____

Any other illnesses, surgeries or hospitalizations since birth and their date(s) of occurrence:_____

_____

Allergies (food, medications, etc.):_____

_____

Current Medications:_____

_____

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Audiologic History

How does the child respond to spoken directions or questions? _____

Does the child respond to loud noise? ☐ Yes ☐ No

Please describe the noise: _____

Has the child ever had a hearing test? ☐ Yes ☐ No If so, when? _____

Does the child experience hearing loss? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both

If he/she does experience hearing loss, which best describes it? Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the child's hearing loss? _____

What do you think is the cause of the child's hearing loss? _____

Does the child have a history of ear infections? ☐ Yes ☐ No

If Yes: First occurrence: _____ Frequency: _____

Most recent: _____ Treatment(s): _____

Has the child ever had ear tubes surgically inserted? ☐ Yes ☐ No

If Yes, when: _____

Has the child ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears

Please check all medical conditions that apply:

____	Dizziness or Unsteadiness	*If checked, is it accompanied by:* ☐ *Vomiting* ☐ *Nausea* ☐ *Ear Noises*
____	Ear Deformity	*If checked,* ☐ *Right Ear* ☐ *Left Ear* ☐ *Both ears*
____	Ear Drainage	*If checked,* ☐ *Right Ear* ☐ *Left Ear* ☐ *Both ears*
____	Ear Pain/Earaches	*If checked,* ☐ *Right Ear* ☐ *Left Ear* ☐ *Both ears*
____	Family History of Hearing Loss	*If checked, who?* _____
____	History of Ear Wax Buildup	
____	Tinnitus/Ringing/Noises in ears	*If checked,* ☐ *Right Ear* ☐ *Left Ear* ☐ *Both ears*
____	Other:	*Please describe:* _____

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