Mary Bridge Genetics Clinic
311 S L Street • Tacoma, WA 98405
Phone 253-403-3476 • Fax 253-403-8674

Welcome

To help us prepare for your child's upcoming visit to the Mary Bridge Genetics Clinic, please take a few minutes to fill out this health information survey prior to your visit.

Patient Information

Child's Name:

Today's date:

Age:

Date of birth:

Primary care provider:

Specialists your child has seen:

ENT specialist (otolaryngologist):

Audiologist:

Eye specialist (ophthalmologist, optometrist):

Other specialists:

Has your child or anyone in the family seen a geneticist before?

Who would you like to receive a copy of the clinic note from your child's visit?

Medical History

Age of diagnosis of hearing loss: ______________________________

Type of hearing loss: ______________________________

Ears affected: ❑ Right ❑ Left ❑ Both

Does your child have a hearing aid or assistive hearing device? ❑ No ❑ Yes

Type: ______________________________

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex:

GENETICS HEARING LOSS EVALUATION INTAKE FORM

General Health Information

Does your child have any health issues? ❑ No ❑ Yes

Has your child ever been hospitalized overnight? ❑ No ❑ Yes

Has your child ever had surgery? ❑ No ❑ Yes

Does your child have any vision problems or need for glasses? ❑ No ❑ Yes

Does your child have any heart problems? ❑ No ❑ Yes

Does your child have any thyroid problems? ❑ No ❑ Yes

Does your child take any medication regularly? (List all medications including prescription, over the counter medications, vitamins, herbal, homeopathic and other remedies.) ❑ No ❑ Yes

Does your child have any allergies? ❑ No ❑ Yes

Birth and Prenatal History

Were there any complications during the pregnancy with your child? ❑ No ❑ Yes

Any fevers or illness in mother during pregnancy? ❑ No ❑ Yes

Any medications taken by mother during pregnancy? ❑ No ❑ Yes

Was your child born at full term? (If no, what was the gestational age?) ❑ No ❑ Yes

Type of delivery: ❑ C-section ❑ Vaginal

Hospital or location of birth: ______________________________

Birth weight: ______________________________

Were there any complications during the delivery or early newborn period? ❑ No ❑ Yes

Did your child pass their newborn hearing screen? ❑ No ❑ Yes

Did your child have jaundice as a newborn? ❑ No ❑ Yes

If yes, please circle treatment required: None, Phototherapy, IV fluid, Blood exchange transfusions

Did your child go to the NICU? ❑ No ❑ Yes

Did your child ever require IV antibiotics? ❑ No ❑ Yes

Developmental History

Do you have any concerns about your child's early development? ❑ No ❑ Yes

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At what age did your child start walking? ______________________

At what age did your child start talking? ______________________

Does your child receive (or previously received) any therapy services?

❑ No ❑ Physical therapy ❑ Occupational therapy ❑ Speech therapy ❑ Other ____________

What grade in school is your child i n at school? ______________________

How is your child doing in school? ______________________

Family History

Is there a history of any of the following in the family? If you answer yes, please add details.

Hearing loss

Relative	Hearing Loss		Additional details if available
	No	Yes	
Mother			
Father			
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			
Mother's mother			
Mother's father			
Father's mother			
Father's father			
Other relative			
Other relative			

Vision loss or vision problems ❑ No ❑ Yes

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Sudden death or unexpected death ❑ No ❑ Yes

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Heart conditions ❑ No ❑ Yes

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Patches of lighter skin / hair; 2 different eye colors in the same individual ❑ No ❑ Yes

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Health Review

Please indicate if your child has any of the following symptoms or health concerns. If yes, please add details.

Sleep problems? ❑ No ❑ Yes ______________________________

Appetite/feeding problems? ❑ No ❑ Yes ______________________________

Snoring? ❑ No ❑ Yes ______________________________

Nasal congestion? ❑ No ❑ Yes ______________________________

Dental problems? ❑ No ❑ Yes ______________________________

Breathing problems? ❑ No ❑ Yes ______________________________
- Chronic cough? ❑ No ❑ Yes
- Chronic wheeze? ❑ No ❑ Yes

Heart problems? ❑ No ❑ Yes ______________________________
- Heart murmur? ❑ No ❑ Yes
- Fainting ? ❑ No ❑ Yes

Abdominal problems? ❑ No ❑ Yes ______________________________
- Constipation? ❑ No ❑ Yes
- Diarrhea? ❑ No ❑ Yes

Urinary or kidney problems? ❑ No ❑ Yes ______________________________

Musculoskeletal problems? ❑ No ❑ Yes ______________________________
- Joint or back problems? ❑ No ❑ Yes
- Broken bones? ❑ No ❑ Yes

Neurologic problems? ❑ No ❑ Yes ______________________________
- Seizures? ❑ No ❑ Yes
- Balance problems? ❑ No ❑ Yes

Attention problems? ❑ No ❑ Yes ______________________________

Blood problems? ❑ No ❑ Yes ______________________________
- Easy bruising? ❑ No ❑ Yes
- Easy bleeding? ❑ No ❑ Yes
- Anemia? ❑ No ❑ Yes

Skin problems? ❑ No ❑ Yes ______________________________
- Rashes? ❑ No ❑ Yes
- Birth marks? ❑ No ❑ Yes
- Patches of lighter skin / hair? ❑ No ❑ Yes

Additional Information

Please share any additional information you feel may be important.

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