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AUDIOLOGY CLINIC
OF NORTHERN ALBERTA
ACNA

PATIENT INFORMATION SHEET

Date _____
Month Day/ Year

Name Title (circle one): Dr. Mrs. Ms. Mr. _____ *other*

First _____ Initial _____ Last _____

Address Street _____

City _____ Province _____ Postal Code _____

Contact information
(please circle your main number or your main alternate contact)

- Home Phone _____
- Work Phone _____ extension _____
- Cell Phone _____
- Email _____

- Alternate Contact 1 _____ Address _____
  Relationship _____ Phone 1 _____ Phone 2 _____
- Alternate Contact 2 _____ Address _____
  Relationship _____ Phone 1 _____ Phone 2 _____

Other information

Date of Birth _____
Month Day/ Year

Health Care Number _____

Social Insurance Number _____
Optional

Spouse's name _____

Family Physician _____

Referral information

How did you hear about us?

_____

_____

_____

If from another patient, who referred you?

_____

Third Party Information

I am covered by (circle one): DVA WCB AB WCB ... _____ NIHB _____ AADL AISH
other province *other*

Claim / Identification Number _____

Release of Information

I, _____, understand that Audiology Clinic of Northern Alberta will only use personal information that I provide, to serve me with the services that I request. Audiology Clinic of Northern Alberta may share my personal information only with organizations that participate in my care including but not limited to my physician, the manufacturer of my products, and any third party participating in the payment of my products and/or services.

I also understand that Audiology Clinic of Northern Alberta abides by Alberta's privacy laws and regulations and has a privacy policy that I can request and/or view online.

I therefore give consent to Audiology Clinic of Northern Alberta to responsibly use my personal information to contact me and share with others only as required to serve my needs.

Signed this _____ day of _____, 20____ in Edmonton, Alberta:

_____
Signed Name

_____
Printed Name

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CASE HISTORY

Patient _____ Date _____

1 Why is your child getting a hearing test?

2 Do you think your child has a hearing problem? ☐ Yes ☐ No

3 Child's parents are: ☐ Married ☐ Divorced ☐ Other

4 Who has legal custody of the child? ☐ Both Parents ☐ Mother ☐ Father ☐ Other

5 Is your child adopted? ☐ Yes ☐ No

6 Has your child had a hearing test before? ☐ Yes ☐ No
Details if 'Yes':

7 Was the mother's pregnancy normal? ☐ Yes ☐ No
Details if 'No':

8 Did the mother experience any of the following during her pregnancy? ☐ Rubella (Measles) ☐ CMV ☐ Other

9 Do any of the following apply to your child's birth history: ☐ In NICU ☐ In an incubator ☐ Premature ☐ Forceps delivery ☐ Breech birth ☐ Caesarean birth ☐ On Oxygen ☐ Jaundiced ☐ Low birth weight ☐ Other complications

10 Are your child's developmental milestone ages: ☐ Early ☐ Late ☐ Normal

11 Does your child report pain or pressure in his/her ear(s)? ☐ Yes ☐ No
Details if 'Yes':

12 Does your child report dizziness or lightheadedness? ☐ Yes ☐ No
Details if 'Yes':

13 Is there a family history of hearing loss? ☐ Yes ☐ No
Details if 'Yes':

14 Does you child have a history of ear infections? ☐ Yes ☐ No
Details if 'Yes':

15 Has your child had ear surgery? ☐ Yes ☐ No
Details if 'Yes':

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CASE HISTORY

16 Has your child had an ear injury? ☐ Yes ☐ No
Details if 'Yes':

17 Has your child had a head injury? ☐ Yes ☐ No
Details if 'Yes':

18 Has your child had a very high temperature? ☐ Yes ☐ No
Details if 'Yes':

19 Has your child had:

☐ Measles	☐ Mumps	☐ Meningitis
☐ Kidney Infection	☐ Encephalitis	☐ Diabetes
☐ Allergies	☐ CMV	☐ Septicemia
☐ Heart Disease	☐ Cancer	

20 What medications does your child take?

21 Has your child been exposed to loud noise? ☐ Yes ☐ No
Details if 'Yes':

22 What grade is your child in?

23 What is your child's progress in school: ☐ Average ☐ Above Average ☐ Below Average

24 Has your child been diagnosed with or suspected of:

☐ PDD	☐ Autism	☐ ADD
☐ Any Syndromes		

25 Does your child have any speech or language difficulties? ☐ Yes ☐ No
Details if 'Yes':

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