Pediatric Hearing Health History

Child's Name: ______________________ Age: ________ Today's Date: ____________

Date of Birth: ________________ Pediatrician: ________________

Home Phone #: ________________ Home Address: ________________

Info Provided By: ________________ Relationship to Child: ________________

Mother's Name: ________________ Father's Name: ________________

Siblings (Names & Ages): ______________________________

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Who referred you to our office: ______________________________

What is your chief concern: ☐ Hearing ☐ Speech/Language Development ☐ Other: ____________

Is there a family history of hearing loss (if yes, who): ______________________________

Pregnancy History

Complications during pregnancy: ______________________________

Medications/drugs used during pregnancy: ______________________________

Alcohol used during pregnancy (how often): ______________________________

Birth History

Birth weight: ____________ How many weeks early/late: ____________

Was your child in intensive care? ________ Reason and how long: ____________

Newborn Hearing Screening: ☐ Pass ☐ Fail ☐ Don't Recall

Other delivery problems: ______________________________

Medical History

Please check all that apply to your child and explain below:

☐ High Fever ☐ Seizures/Convulsions ☐ Past/Present Medications: ____________

☐ Hospitalizations/Surgeries (including myringotomy with/without insertion of tympanostomy tubes)

Medical Conditions: ______________________________

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Development and Social History

Does your child: ☐ interact well with others his/her age ☐ have behavioral problems

What age did your child: Sit Alone: ________ Walk Alone: ________ Use 1st word: ________

Use 1st Sentence: ________ Describe any slowly developing behavior: ____________

Keeping your child's age in mind, please rate the following:

Motor coordination and balance	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to keep attention on activity	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to follow directions	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to speak clearly	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Hearing History

Do you now or have you ever had any concerns about your child's hearing? ☐ Yes ☐ No

Does your child have a permanent hearing loss that you are aware of? ☐ Yes ☐ No

If so, please describe (ex. 1 ear only, can't hear high pitches, etc.) ______________________________

Has a teacher ever expressed concern about your child's hearing? ☐ Yes ☐ No

Does your child respond to sound consistently? ☐ Yes ☐ No

Do you feel you need to repeat things for your child in order to be understood? ☐ Yes ☐ No

Does your child say "What?" or "Huh?" frequently? ☐ Yes ☐ No

Do you need to raise your voice for your child to respond? ☐ Yes ☐ No

Does your child sit close to the TV or turn up the volume? ☐ Yes ☐ No

Does your child appear to have difficulty understanding speech in background noise? ☐ Yes ☐ No

Ear History

Has your child ever had an ear infection? ☐ Yes ☐ No If yes, how many: __________

When was your child's most recent ear infection? ______________________________

Has your child ever been treated with antibiotics for an ear infection? ☐ Yes ☐ No

Is your child currently on antibiotics for treatment or prevention of ear infections? ☐ Yes ☐ No

Has your doctor ever observed fluid behind your child's eardrums? ☐ Yes ☐ No

Has your child ever seen an Ear, Nose, & Throat (ENT/Otolaryngologist) specialist? ☐ Yes ☐ No

Has your child ever received pressure equalizing tubes for chronic ear infections? ☐ Yes ☐ No

How many sets of tubes? ______________ At what ages? ______________________

Does your child have frequent colds, allergies, or congestions? ☐ Yes ☐ No

Other Important Information Not Provided Above

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Signature of Person Providing Information