Pediatric Hearing Health History

Child's Name: ______________________________ Date of Birth: ____________________

Mother's Name: ____________________ Father's Name: ______________________________

Siblings (Names & Ages): ____

Info Provided By: ____________________ Relationship to Child: __________________________

Primary Care Physician: ____

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): ______________________________

Does your child currently receive speech therapy: _____ If yes: how many times per week: ________

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: ____

Medical Conditions: ____

____

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:

(Please complete back of form).

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: ______________________________ Date: ________________

Please bring this completed form to your appointment.