Hearing Health Center

PEDIATRIC HEARING HISTORY

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Telephone#: _____

☐ Male ☐ Female

Medical History

1. Did your child have an infection at birth? (Please circle)

   A. None B. Cytomegalovirus C. Rubella

   D. Herpes E. Syphilis F. Toxoplasmosis

2. Did your child have asphyxia or breathing problems at birth? _____

3. Were any blood transfusions given? _____ Please describe: _____

   _____

4. Was your baby in an Intensive Care Unit? _____

5. Were there any congenital malformations involving the head, neck or ears?

   _____

6. What was your baby's weight? _____

7. Was your baby born prematurely? _____ How many weeks? _____

8. Did your baby have elevated bilirubin (jaundice)? _____

9. Was your baby treated with any antibiotics? _____ If so, what? _____

10. Did your baby ever have meningitis? _____ At what age? _____

11. Is there any family history of hearing problems in early childhood? _____ (Please circle)

    A. Mother B. Father C. Grandmother D. Grandfather

    E. Brother F. Sister G. Uncle H. Aunt

    I. Cousin J. Other

12. Does your child have any other associated disability? (Please circle)

    A. Blindness or vision disorder
    B. Cerebral Palsy
    C. Developmental disability
    D. Seizure disorder
    E. Down Syndrome
    F. Learning disability
    G. Other _____

13. When did you last consult a physician about your child's ears? _____
14. Has your child had any earaches? _____ Drainage? _____ Which ear? _____
15. Any medical treatment of your child's ears? _____
16. Has your child experienced any dizziness? _____
17. Is your child receiving any medication? _____

Hearing and Speech History

18. Do you think your child has a hearing problem? _____
19. How old was your child when you first noticed a loss of hearing? _____
20. Has your child's hearing been tested before? _____
21. Does your newborn baby startle to loud sounds? _____
22. Does your 3 month old stop moving or stop crying when you call him? _____
23. Does your 6 month old enjoy noise-making toys? _____
24. Does your 9 month old babble frequently? _____
25. Does your one year old respond to simple commands ("no no")? _____
26. At what age did your child babble? _____ First word _____

    Short (2-3 word) sentences? _____
27. How many words does your child have in his/her vocabulary? _____
28. Does your child's use speech frequently, occasionally, seldom or never? _____

29. Is your child's speech clear? _____

30. What was your reason for coming to Hearing Health Center today? _____

_____

How did you hear about our services?

- □ Doctor Referral
- □ School
- □ Friend
- □ Yellow pages
- □ Previous patient
- □ Advertisement
- □ Other _____

_____

_____

Authorization For Release of Information

I authorize the Hearing Health Center to release any part or all of my records to those persons listed below:

	Name	Address
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Signature: _____

Relationship to patient: _____

Date: _____