Pediatric Hearing Health History

Date ______________ File# ______________

Patient Name____DOB______________Male ☐ Female ☐

Primary Concerns for this Visit ____

I. Prenatal and Birth History

Length of pregnancy _______________________________________ Birth Weight _________________________

List medications or drugs (including alcohol) used during pregnancy _______________________________

Remarkable pregnancy: Y / N __________________ Complicated delivery: Y / N___________________________

Mother's illness during pregnancy (Herpes, Toxoplasmosis, CMV, Syphilis, Rubella): Y / N __________________

II. After birth, your child had:

Breathing difficulties: Y / N______________________ Head trauma / defect: Y / N___________________________

Admission to the intensive care unit: Y / N (how long) ____

Head, neck or ear abnormalities: Y / N Jaundice (high bilirubin): Y / N & treatment (transfusion, phototherapy)

Surgery: Y / N ________________________________ Diagnosis of neurologic condition: Y / N ________________

Diagnosis or suspicion of a syndrome or other disorder: Y / N____

III. Ear and Medical History

Number of ear infections: ___ At what age resolved: ______ P.E. Tubes placed: Y / N_______________________

Ear problem in the past six months: Y / N _________Ear pain and fullness: Y / N ___________________________

Has your child been seen by an Ear, Nose & Throat specialist: Y / N _____________________________________

Has your child been seen by an Audiologist for a hearing assessment? Y / N ____________________________

Passed newborn hearing screening: Y / N____

Noise exposure: Y / N ________________________________ Tinnitus: Y / N ________________________________

Balance & coordination: Y / N ___________________Head trauma and concussion: Y / N ____________________

Allergies: Y / N________________________________ Frequent cold or sinus infections: Y / N ________________

Other illnesses: Y / N __________________________ Overall physical/general health: _______________________

IV. Family History

Family history of hearing loss before age 40: Y / N ____

Family history of speech / language / communication disorders: Y / N ____________________________________

V. Developmental History: Speech and Language

Concerns about speech and language: Y / N ___________________ Is your child's voice unclear? Y / N ________

Does your child have difficulty expressing him / herself: Y / N ____

Do you have concerns about your child's ability to understand speech? Y / N ____________________________

Do you or others have difficulty understanding what your child says? Y / N ________________________________

Do you have concerns about your child's fluency of speech? Y / N ____

Does your child have difficulty with reading and / or writing? Y / N____

Has your child received a speech and language evaluation? Y / N____

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Therapy? Y / N ____________How long? ______ Has your child made progress? Y / N _______________

Has your child received a literacy evaluation? Y / N ____

Was your child diagnosed with a reading and / or writing disorder? Y / N __________________________________

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Therapy? Y / N ____________How long? ______ Has your child made progress? Y / N _______________

VI. Developmental History: Cognition

Do you have concerns about your child's cognitive ability? Y / N ____

Has your child received a cognitive assessment by a psychologist? Y / N __________________________________

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Therapy? Y / N ____________How long? ______ Has your child made progress? Y / N _______________

VII. Developmental History: Attention

Do you have concerns about your child's attention and ability to focus? Y / N ______________________________

Does your child have difficulty following directions? Y / N ____

Has your child been evaluated for attention disorder? Y / N____

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Treatment: Y / N _________________ How long? _________Has your child made progress? Y / N

VIII. Developmental History: Fine and Gross Motor Skills, and Sensory Integrations

Do you have concerns about your child's fine and gross motor skills and / or sensory integration? Y / N _______

Has your child has been evaluated by an Occupational and/or Physical Therapist? Y / N ____________________

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Therapy? Y / N ____________How long? ______ Has your child made progress? Y / N _______________

IX. Developmental history: Spectrum Disorder (Pervasive Developmental Disorders, Autism)

Do you have concerns about autism spectrum disorder: Y / N ____

Has your child been evaluated for autism spectrum disorder? Y / N _______________________________________

When? _____________ Where? _________________ Diagnosis? Y / N ______________________________

Treatment? Y / N __________How long? ______ Has your child made progress? Y / N _______________

X. Developmental history: Vision and Visual Processing

Do you have concerns about your child vision and/or visual processing? Y / N ____________________________

Has your child been evaluated for a vision problem and/or visual processing? Y / N ______________________

When? ____________ Where? ________________ Diagnosis? Y / N ____________________________

Treatment? Y / N __________How long? ______ Has your child made progress? Y / N ______________

XI. Developmental history: Other Developmental Delays Y / N ______________________________

XII. Academic Performance

Does your child have a problem listening or understanding? Y / N ______________________________________

Does your child have difficulty with any subjects at school: Y / N ______________________________________

Your child's best subjects at school: ____

Your child's challenging subjects at school: ____

Time that it takes your child to complete homework assignment: _______________________________________

Your child requires extra help or requires more effort: Y / N ____

Teacher concerns: ____

Your child's subjects and grades: ____

Tutoring / special services: Y / N ____

How long? _____ Where? ____ Is it helping? Y / N

Your child has an IEP / 504 Plan: Y / N ____

The Individualized Educational Plan (IEP) is a plan or program developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives specialized instruction and related services.

The 504 Plan is a plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

XIII. Behaviors, Characteristics, and Social skills

Difficulty listening in noisy environments: Y / N

Difficulty following verbal directions: Y / N

Auditory fatigue: Y / N

Reverses words, letters or numbers: Y / N

Speaks with flat or monotone speech: Y / N

Poor hand and feet coordination: Y / N

Hearing protection: Y / N

Frequently asks for repetition: Y / N

Difficulty telling the direction of sounds: Y / N

Sensitive to normal loud sounds: Y / N

Difficulty sounding out words: Y / N

Difficulty with note-taking: Y / N

Difficulty with playing instruments: Y / N

Poor social skills / awkward in social situations: Y / N

Other Concerns: ____