Pediatric Hearing Health Assessment

TO BE COMPLETED BY PARENT/GUARDIAN

Patient Name ___________________________________________ Sex ________ Date ____/____/______
First Last MI
Parent/Guardian Name ___________________________________ Relationship to Patient ____________________
First Last MI
Main concerns / reason for referral: ____________________________________________________________

HEARING HISTORY

Are you concerned about your child’s hearing? ☐ Yes ☐ No

If yes, for how long have you been concerned? __________________________________________________

Has your child’s hearing ever been tested? ☐ Yes ☐ No If yes, when was his/her last test? _______________

Is your child responding to speech/environmental sounds? ☐ Yes ☐ No

If no, please explain ____________________________________________________________________________

Have hearing aids or other hearing devices ever been recommended for your child? ☐ Yes ☐ No

Is there a family history of childhood hearing loss? ☐ Yes ☐ No If yes, explain: ___________________________

SPEECH DEVELOPMENT

Do you have any concerns regarding your child’s speech and language development? ☐ Yes ☐ No

If yes, explain: ______________________________________________________________________________

How many intelligible words does your child have?__________________________________________________

Is your child combining words in sentences and phrases? _____________________________________________

Does your child follow simple directions? __________________________________________________________

How do you feel about your child’s overall development? ____________________________________________
PREGNANCY QUESTIONS

Was your child carried to full term (38 – 40 weeks)? □ Yes □ No, _______ weeks

Were there any complications during pregnancy? □ Yes □ No

If yes, please explain __________________________________________________________

Was your child admitted to the NICU for longer than 5 days? □ Yes □ No

Medications at birth? □ Yes □ No  If yes, please list: __________________________________________________________

Jaundice? □ Yes □ No  If yes, how was it treated? __________________________________________________________

Did your child pass his/her newborn hearing screening? □ Right ear □ Left ear □ Both ears

HEALTH QUESTIONS

Has your child been diagnosed with any medical conditions? __________________________________________________________

Is your child currently taking any medications? __________________________________________________________

Has your child had any ear infections? □ Yes □ No  If yes, how many? __________ Last episode? __________

Has your child had PE tubes? □ Yes □ No  If yes, when did he/she receive them? _________ How many sets? _______

Has your child had any ear injuries or head trauma? □ Yes □ No  If yes, explain: __________________________________________________________

Has your child had any eye/dental exams? □ Yes □ No  Concerns? __________________________________________________________

Is there a family history of disease? □ Yes □ No  If yes, explain: __________________________________________________________

Do you have any additional information that we should know? __________________________________________________________

How did you find out about us?

□ Advertisement  □ Insurance  □ Referred by Patient  □ Referred by Physician

□ Health Fair  □ Other health organization

□ Internet/Website  □ Other __________________________________________________________