Augusta Hearing and Balance

Pediatric Hearing History

Child's name:______________________________ **Date:**__________________

Parent/Guardian name: ____

Who brought the patient to this appointment: ☐Mother ☐Father ☐Other: __________

Do you have concerns about your child's hearing? YES NO

If yes, what are your concerns? ____________________________________

Is this hearing test for speech? YES NO

Is there a family history of hearing loss before age 30? YES NO

Did your child pass the newborn hearing test? YES NO

Length of pregnancy ______ weeks In NICU/PICU? YES NO

Has your child ever had his/her hearing tested? YES NO
(Other than the newborn hearing test?)

Does your child have a history of ear infections? YES NO

Does your child have tubes? YES NO

If so, when were they placed? ____________________________________

Has your child had other ear surgery? YES NO

If so what? ____

Has your child been using a prescribed nasal spray? YES NO

Are there concerns with:

ADHD/ADD? YES NO
Autism? YES NO
Speech disorder? YES NO
Learning Disability? YES NO

Head trauma? YES NO
Physical Impairments? YES NO
Neurological issues? YES NO