Augusta Hearing and Balance

Pediatric Hearing History

Child's name:_____ **Date:**_____

Parent/Guardian name: _____

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

Why was your child referred for a hearing examination today? _____

_____

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

If yes, what are your concerns? _____

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

Has your child ever had his hearing tested? YES NO

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

Has your child had surgery on his/her ears? YES NO

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

Did your child pass the newborn hearing test upon hospital discharge? YES NO

Are there concerns with:

ADHD/ADD?	YES	NO	Head trauma?	YES	NO
Autism?	YES	NO	Physical Impairments?	YES	NO
Speech disorder?	YES	NO	Neurological issues?	YES	NO
Learning Disability?	YES	NO			