



**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**  
**AUDIOLOGY ASSOCIATES OF NORTH FLORIDA**

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**PEDIATRIC HEARING HISTORY: BIRTH TO 3 YEARS**

**Child's Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

Do you have legal guardianship?

NO YES

What is the primary reason for today's visit?

\_\_\_\_\_

\_\_\_\_\_

**BIRTH/MEDICAL HISTORY**

- Were there any complications during pregnancy or delivery? NO YES  
 If yes, please list: \_\_\_\_\_
- Did the birth mother have rubella (measles), cytomegalovirus (CMV),  
 herpes, toxoplasmosis or syphilis during pregnancy? NO YES
- Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz  
 Was your baby premature (less than 37 weeks)? NO YES  
 If yes, delivered at how many weeks? \_\_\_\_\_
- Did your baby pass the newborn hearing screening? NO YES UNKNOWN  
 If no, which ear?  Right  Left  Both  
 Birth Hospital: \_\_\_\_\_
- Did your baby receive oxygen or mechanical ventilation after delivery? NO YES  
 If yes, how long? \_\_\_\_\_
- Was your baby cared for in a special care nursery (NICU)? NO YES  
 If yes, how long? \_\_\_\_\_
- Was your baby diagnosed with jaundice (hyperbilirubinemia)? NO YES  
 Was a blood transfusion required?  Yes  No
- Did your baby received ECMO (forced oxygen into tissues)? NO YES
- Is there a family history of hearing loss: One or more blood relatives  
 of the child had permanent hearing loss in early childhood? NO YES  
 If yes, Who?  parent,  grandparent,  aunt,  uncle,  
 child's first cousin,  brother,  sister.  
 Baby's Mother's or Father's family? \_\_\_\_\_
- Has your child been hospitalized since birth? NO YES  
 If yes, when? \_\_\_\_\_
- Has your child required IV antibiotics or chemotherapy? NO YES
- Has your child had an infection such as meningitis, mumps, measles,  
 MRSA, or RSV? NO YES
- Has your child experienced head trauma? NO YES  
 (i.e. a serious fall causing a concussion or skull fracture)
- Has your child been diagnosed with a particular syndrome or disorder? NO YES  
 (i.e. Down Syndrome, cleft palate) Specify: \_\_\_\_\_
- Has your child had more than 4 ear infections in the past 12 months? NO YES  
 Date of the last ear infection? \_\_\_\_\_
- Has your child had tubes? NO YES

List any medical conditions your child has been diagnosed with: \_\_\_\_\_

List any medicine your child is currently taking: \_\_\_\_\_

List any allergies your child has: \_\_\_\_\_

### **SURGICAL HISTORY**

List any previous surgeries your child has undergone: \_\_\_\_\_

### **SPEECH, LANGUAGE AND AUDITORY DEVELOPMENT**

Do you have any concern regarding your child's speech and language development?      NO      YES  
If yes, what is your primary concern? \_\_\_\_\_  
\_\_\_\_\_

Does your child speak more than one language?      NO      YES

Is your child currently or has your child ever received speech and language therapy?      NO      YES  
Where? \_\_\_\_\_  
For how Long? \_\_\_\_\_  
How Often? \_\_\_\_\_

Do you have any concerns about how your child talks or expresses his/her wants and needs?      NO      YES

Do you have any concerns about your child's ability to follow directions or understand what is being said to him/her?      NO      YES

How many words (approximately) does your child have in his/her vocabulary?      NONE      1-5      6-10      11-20      21-50      50+

Does your child put two words together (i.e. mommy more, daddy bye-bye)?      NO      YES

Does your child speak in phrases or short sentences?      NO      YES

Does your child seem to respond to sounds in the environment that are easy to hear, unusual, or otherwise alerting (i.e. dog bark, door bell)?      NO      YES

Does your child seem to respond to his/her name or noise when you would have expected him/her to respond?      NO      YES

Has your child been diagnosed with developmental delay?      NO      YES

Is your child receiving any other type of therapy or services?      NO      YES  
If yes, please list: \_\_\_\_\_

Please list anything else you believe would be helpful for us to know when assessing your child?  
\_\_\_\_\_  
\_\_\_\_\_

How Did You Hear About Our Center?      FRIEND / DOCTOR REFERRAL / NEWSPAPER / TV AD / RADIO / SEMINAR / TELEPHONE BOOK / OTHER: \_\_\_\_\_

**I have completed this form and to the best of my knowledge it is accurate. I understand that this document will be used for medical decision making.**

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_