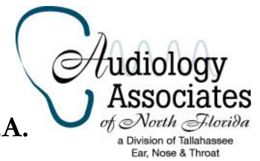

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA
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PEDIATRIC HEARING HISTORY: BIRTH TO 3 YEARS

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:** _______________________