TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA
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Tallahassee, FL 32308
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PEDIATRIC HEARING HISTORY: 4 TO 14 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?

_____

_____

ACADEMIC PERFORMANCE

Has your child been referred to this center from a hearing screening? NO YES
If yes, which ear failed? □ Right ear □ Left ear □ Both

What grade is your child in at school? _____

Has your child ever repeated a grade? NO YES
If YES, which grade? _____

Has your child's teacher expressed concern regarding his/her hearing ability? NO YES

Overall academic performance: GOOD FAIR BELOW AVERAGE

MEDICAL HISTORY

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.
Child's Mother's or Father's family? _____

Has your child been hospitalized since birth? NO YES
If yes, when? _____ why? _____

Has your child required IV antibiotics or chemotherapy? NO YES

Has your child had an infection such as meningitis, mumps, or measles, MRSA, or RSV? NO YES

Has your child ever had a fever in excess of 104˚? 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 specific syndrome or disorder? NO YES
(i.e. Down Syndrome, cleft palate, Autism Spectrum Disorder) 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? If yes, when? _____ NO YES

Has your child complained of ear fullness/pressure? NO YES

Does your child complain of ringing/noises in ears? NO YES
List any current 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? _____
_____

Is your child currently or has your child ever received speech and language therapy? NO YES
Where? _____
What Length of Time? _____
How Often? _____

Do you have any concerns regarding your child's hearing ability? NO YES

Has your child ever expressed concern regarding his/her hearing? NO YES

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

Has your child ever been exposed to excessive noise (gun shot, explosion, loud music, car racing, fireworks, etc…)? NO YES

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:** _____