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:** _____