

Patient: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Provider: \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

What is the primary purpose of this hearing test? \_\_\_\_\_

HEARING HISTORY

- Yes / No 1. Is a hearing loss suspected by anyone? If yes, whom? \_\_\_\_\_
- Yes / No 2. Do you suspect a hearing loss? (If no, skip to questions #3)
- A. At what age did you begin to suspect a hearing loss? \_\_\_ months \_\_\_ years
- B. Does the hearing loss fluctuate? Yes / No
- Yes / No 3. Does any family member have a hearing problem? Yes / No (If no, skip to question #4)
- A. How is this person related to the patient? \_\_\_\_\_
- B. What was the cause of the hearing loss? \_\_\_\_\_
- Yes / No 4. Does the child respond to sounds? Check all that the child does respond to.
- \_\_\_ whisper \_\_\_ door slam \_\_\_ parent calling child's name \_\_\_ doorbell/phone
- Yes / No 5. Does the child look in the direction a sound came from?
- Yes / No 6. Do you have concerns about how the child talks? (If no, skip to question #7)
- A. Does the child say at least 10 words? Yes / No
- B. Does the child say 2-3 word sentences? Yes / No
- C. Can non-family members understand your child's speech? \_\_\_\_\_
- Yes / No
- D. Does the child see a speech therapist? Yes / No
- Yes / No 7. Has your child had a hearing test before? (If no, skip to question#8)
- A. When did this occur and where? \_\_\_\_\_
- B. What were the results? \_\_\_\_\_
- Yes / No 8. Has the child ever tried or worn hearing aids? (If no, skip to question #9)
- A. Which ear? Right/Left/Both
- B. Since what age? \_\_\_\_\_
- C. Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_

PREGNANCY AND BIRTH

- Yes / No 9. Were the parents' blood types compatible?
- Yes / No 10. Was the delivery premature? If yes, length of pregnancy: \_\_\_\_\_ weeks
- Yes / No 11. Were drugs taken during the pregnancy? What/when: \_\_\_\_\_
- Yes / No 12. Does the mother or child have a history of infectious diseases? Check all that apply:
- \_\_\_ Rubella \_\_\_ Toxoplasmosis \_\_\_ Syphilis \_\_\_ Hepatitis B \_\_\_ Herpes
- \_\_\_ Fetal Alcohol Syndrome \_\_\_ Cytomegalovirus (CMG)
- Yes / No 13. Was the delivery normal? If not, describe: \_\_\_\_\_
- Yes / No 14. Was the infant's birth weight normal? If not what was the birth weight? \_\_\_\_\_
- Yes / No 15. Was the child ever admitted to a neonatal intensive care unit?
- Yes / No 16. Was the infant's condition (APGAR score) normal at birth?
- If not, describe: \_\_\_\_\_

MEDICAL HISTORY

- Yes / No 17. Has the child had any of the following? Indicate the age it occurred:  
\_\_\_ chicken pox \_\_\_ measles \_\_\_ mumps \_\_\_ scarlet fever \_\_\_ meningitis  
\_\_\_ fever over 104 degrees \_\_\_ encephalitis \_\_\_ blood disease  
Complications during the above? \_\_\_\_\_
- Yes / No 18. Does the child have any other medical problems?  
Describe: \_\_\_\_\_
- Yes / No 19. Does the child take any medications? If yes, for what? \_\_\_\_\_
- Yes / No 20. Does the child have a visual problem?
- Yes / No 21. Does the child have difficulty chewing or swallowing?
- Yes / No 22. Has the child's development differed from other children his/her age?  
If so, how? \_\_\_\_\_
- Yes / No 23. Has the child had frequent ear infections or middle ear fluid? How often? \_\_\_\_\_  
A. How has this been treated? \_\_\_\_\_
- Yes / No 24. Does the child have difficulty in school? If yes, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_