DeFatta
ENT & ALLERGY

Name: _____

DOB: _____

Pediatric Hearing Health History

Is there a family history of hearing loss? ☐ Yes ☐ No

If yes, who? _____

Did your child pass the NBHS? ☐ Yes ☐ No

Has your child recently had any ear pain? ☐ Yes ☐ No

Has your child recently had any ear drainage? ☐ Yes ☐ No

Has your child had any pressure in their ears? ☐ Yes ☐ No

Has your child had ringing/buzzing in their ears? ☐ Right ☐ Left ☐ Both ☐ No

Does your child fall or lose balance easily? ☐ Yes ☐ No

Explain: _____

Does your child have a history of ear infections/ear surgery? ☐ Yes ☐ No

Does your child have a history of noise exposure? ☐ Yes ☐ No

Does your child respond to loud sounds? ☐ Yes ☐ No

Do you have concerns regarding your child's speech? ☐ Yes ☐ No

Has your child had a hearing test done recently? ☐ Yes **When/where:** _____ ☐ No

School Information: _____ **Grade:** _____ **Teacher:** _____

Birth/Pregancy History

Any birth or pregnancy complications? ☐ Yes ☐ No

If yes, please explain: _____ **Length of pregnancy:** _____

Did your child have a stay in the NICU? ☐ Yes ☐ No **Length of stay?** _____

Please check any of the conditions that occurred during pregnancy:

☐ **Rh Incompatibility** ☐ **Substance Abuse** ☐ **Alcohol Abuse** ☐ **CMV** ☐ **Lack of oxygen**

☐ **Infections** ☐ **Rubella/German Measles** ☐ **Communicable Diseases** ☐ **Venereal Disease** ☐ **Toxoplasmosis**

General Health

Has your child been diagnosed with any medical conditions or developmental disabilities? □Yes □ No

If yes, please list diagnoses.

_____

_____

Please check all that apply and list date of occurrence:

☐ **Measles** ☐ **Tonsilitis** ☐ **Chicken Pox** ☐ **Allergies** ☐ **Mumps** ☐ **Frequent Colds**

☐ **Scarlet Fever** ☐ **Ear Infections** ☐ **Meningitis** ☐ **Sinsusitis** ☐ **Encephalitis** ☐ **Seizures**

☐ **Flu** ☐ **High Fevers** ☐ **Head injury**

Any other serious illness or surgery? _____

Amplification History

Has your child ever worn hearing aids? ☐ **Right** ☐ **Left** ☐ **Both** ☐ **No**