



CHILD HEARING HISTORY

Name: _____ Age: _____ Birthdate: _____

Hospital of Birth: _____ Family Physician: _____

Referring Physician: _____

Please answer the following questions:

YES NO

Do you have concern for your child's hearing?
If yes, please explain _____

Did you experience any pregnancy or birth complications?
If yes, please explain _____

Did your child pass their Universal Newborn Hearing Screening?
If no, which ear DID NOT pass _____

Did your child have a NICU stay?
If yes, how long? Did they receive blood transfusions, IV antibiotics, or use a ventilator/incubator to assist in breathing? _____

Has your child had high fevers or contagious diseases that have required consultation of a doctor?

Does your child have a history of ear infections or middle ear fluid?

Has your child ever been to an ear, nose, and throat doctor?
If yes, who and when? _____

Has your child ever had ear, throat, nose, or palate surgery?
If yes, when? _____

Is there a family history of childhood hearing loss?
If yes, who? _____

Is there any concern for speech development?
If yes, what are your concerns? _____

Is your child receiving any services (i.e., speech language therapy, occupational therapy, physical therapy)?

X

Signature

Relationship to Patient

Date

