Oregon Ear, Nose and Throat Center

Pediatric Hearing Health History Form

Date: ____/____/_____

Name_____DOB:_____/_____/_____

School: _____ Grade:_____

Parent/Guardian's Name: _____

Person Completing Form:_____

Birth Hospital: _____ Pediatrician's Name_____

What are your concerns about your child's hearing?

_____

_____

Has your child's hearing been tested before? (including newborn infant screening) O Yes O No

If yes, when? Where? _____

Results: _____

Is there a family history of childhood hearing loss? O Yes O No

If yes, relationship to child: _____

Can you get your child's attention by calling his/her name? O Yes O No

Does your child understand what you say? O Yes O No

Does your child follow directions correctly? O Yes O No

Do you have concerns about your child's speech/language? O Yes O No

If yes, explain: _____

Are you concerned about how your child is doing in school? O Yes O No

If yes, explain: _____

Prenatal History

Was mother exposed to viral disease during pregnancy? O Yes O No

If yes, please list: _____

Were any drugs/medications taken during pregnancy? O Yes O No

If yes, please list: _____

Any maternal illness during pregnancy (i.e. Rh incompatibility, gestational diabetes, blood transfusions, etc.)? O Yes O No

If yes, please list: _____

Birth History

Was child full term_____ or premature_____ Birth weight_____

Were there any complications? O Yes O No

If yes, please list: _____

Were there any breathing problems? O Yes O No

If yes, please list: _____

Oxygen treatment: Yes O No O If yes, for how long?_____

Any known or suspected syndromes? O Yes O No

If yes, please list: _____

Were there any required medications (including antibiotics)? O Yes O No

If yes, please list: _____

Was the child placed in intensive care? O Yes O No

If yes, how long? _____

Infant/Childhood History

At which age did your child: Sit alone_____ Crawl _____ Walk _____
Use First words _____ Sentences _____

Is your child currently taking any medication? O Yes O No

If yes, what for? _____

Has your child ever been hospitalized? O Yes O No

If yes, what for? _____

History of ear infection? O Yes O No

If yes, how many per year? _____

History of ear surgeries? O Yes O No

Has your child had any of the following?

Meningitis	O Yes O No Age _____	Tonsillectomy/Adenoidectomy	O Yes O No Age _____
Measles	O Yes O No Age _____	Learning Difficulties	O Yes O No Age _____
Rubella	O Yes O No Age _____	Balance/Coordination Difficulties	O Yes O No Age _____
Cytomegalovirus (CMV)	O Yes O No Age _____	Attention Deficit Disorder	O Yes O No Age _____
Chicken pox	O Yes O No Age _____	Toxoplasmosis	O Yes O No Age _____
Encephalitis	O Yes O No Age _____	Syphilis	O Yes O No Age _____
Pneumonia	O Yes O No Age _____	Herpes	O Yes O No Age _____
Diabetes	O Yes O No Age _____	Jaundice	O Yes O No Age _____
High Fevers (+104^{o}F)	O Yes O No Age _____	Mumps	O Yes O No Age _____
Frequent Colds	O Yes O No Age _____	Allergies	O Yes O No Age _____
Neurological abnormalities	O Yes O No Age _____	Blood transfusions	O Yes O No Age _____
Seizures	O Yes O No Age _____	Severe injuries or falls	O Yes O No Age _____
Vision Disorder	O Yes O No Age _____	Whooping cough	O Yes O No Age _____
Tubes in Ears	O Yes O No Age _____	Cardiovascular abnormalities	O Yes O No Age _____
Cancer	O Yes O No Age _____	Other: _____	O Yes O No Age _____

List any information not noted above that you feel we should be aware of:

_____
_____
_____
_____