HEARING HEALTH CENTERS | NELSON HEARING AID SERVICE | FAIRMONT HEARING AID SERVICE | WORTHINGTON HEARING AID SERVICE

PEDIATRIC HEARING HEALTH ASSESSMENT

Today's Date: _____

Name: _____ Age: _____ DOB: ____/____/____

Medical History

My child's current general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Pregnancy / Birth (Check any that apply)

☐ Complications during pregnancy ☐ Complications during labor/delivery ☐ Child given medications at birth

Has your child ever had or been diagnosed with any of the following? (Check all that apply)

☐ Measles/Mumps ☐ Chicken Pox ☐ Meningitis ☐ Allergies ☐ Sinus issues

☐ Seizures ☐ Surgery ☐ Developmental/health problems ☐ Trauma to head/neck

☐ Other

If you checked any of the above, please describe:

_____

_____

Current medications (If you have a list, we can make a copy):

_____

_____

Education and Services

What school is your child currently attending (if applicable)? _____ Grade: _____

Does your child's hearing problem affect his/her school performance? ☐ Yes ☐ No

Does your child have a current IEP? ☐ Yes ☐ No

If yes, for what? Please have the school send a copy to this clinic.

_____

_____

What intervention services does your child receive? (i.e., speech therapy, physical therapy)

_____

_____

If applicable, please list the following professionals involved in your child's care:

School Audiologist: _____

Speech Language Pathologist: _____

Teacher: _____

Primary Care Physician: _____

Ear, Nose and Throat Physician: _____

Hearing History

Did your child pass his/her Newborn Hearing Screening? ☐ Yes ☐ No

If no, what follow-up testing was done?

_____

_____

Has your child been diagnosed with a hearing loss? ☐ Yes ☐ No

If yes, when and where was the hearing loss diagnosed?

_____

_____

Do you feel that your child hears well? ☐ Yes ☐ No

If yes, explain:

_____

Do you often need to repeat things for your child to understand? ☐ Yes ☐ No

Does your child hear the same from day to day? ☐ Yes ☐ No If no, explain: _____

Does your child favor one ear? ☐ Yes ☐ No If, so, which ear? ☐ Right ☐ Left

Has your child failed a hearing screening at school? ☐ Yes ☐ No If yes, when? _____

Has your child ever had an ear infection? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both

If yes, how many times? _____ When was the most recent infection? _____

Has your child had tubes in his/her ears? ☐ Yes ☐ No If yes, when? _____

Does your child ever complain of ear noises such as ringing or buzzing? ☐ Yes ☐ No

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

If yes, who and at what age were they diagnosed?

_____

_____

Has your child had any ear surgery? ☐ Yes ☐ No

Has your child ever had to have earwax removed? ☐ Yes ☐ No

Is your child sensitive to loud sounds? ☐ Yes ☐ No

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

If yes, explain:

_____

_____

Does your child wear hearing aids? ☐ Yes ☐ No

If yes: ☐ Right ☐ Left ☐ Both ears

Where were their aid(s) fit: _____

Make and model of aid(s) _____

Does your child wear his/her aids during all waking hours? ☐ Yes ☐ No

Please list any concerns you have about your child's hearing aid(s).

_____

_____

Is there anything else about your child that you think we should know?

_____

_____

_____

_____