NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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Infant / Child History – Birth to age 12

Date: _____

Patient name: _____ Date of Birth: _____ Gender: ☐Male ☐Female
(First, Middle Initial, Last)

Parent/Guardian Name: _____

1. Do you feel your child has a hearing problem? ___ *Yes* ___ *No*
If *YES*, when did you first notice it? _____

2. How does your child respond to sound? (Please mark all that apply)
____ Startles to loud noise
____ Notices sounds at home (Car, dog, door bell, television, etc.)
____ Locates source of sound
____ Hears you call from another room
____ Watches your face intently
____ Turns up the volume on the T.V.
____ Other, please explain_____

3. Is there a family history of hearing loss? ____ *Yes* ____ *No*
If *YES*, what is their relationship to your child? _____

4. Was there anything unusual about the pregnancy? ____ *Yes* ____ *No*
(Maternal illness, diagnosis of syphilis, herpes, toxoplasmosis, influenza, CMV, exposure to chemicals, drugs, radiation, measles, mumps, chickenpox, or any other complications)
If *YES*, please explain: _____
_____

5. A. Was there anything unusual about the delivery? ____ *Yes* ____ *No*
(Long labor, forceps/assisted delivery, cesarean section, bleeding, premature membrane rupture, or any other complications)
If *YES*, please explain: _____
_____

B. Where was the patient born? (Facility, city, state):_____

C. Did the patient have a NBHS (New Born Hearing Screening)? ____ *Yes* ____ *No*

D. What were the results of the NBHS? ____ *Pass* ____ *Refer*

(PLEASE TURN OVER FOR PAGE 2)

6. Were there any factors that put your child at a higher risk for hearing loss? (Please check all that apply)

____ Family history of congenital or delayed onset childhood hearing loss
____ Low birth weight (less than or equal to 1500 grams)
____ Maternal substance abuse (prescription or illicit drug use)
____ Low Apgar score (a score of 4 or less at on minute or a score of 6 or less at five minutes following birth, on five objective signs; heart rate, respiratory effort, muscle tone, response to catheter in nostril, and skin tone)
____ Mechanical Ventilation (more than 5 days)
____ Craniofacial or skeletal abnormalities (slight to obvious malformations of the head, neck, mouth, ears, etc.)
____ Cleft lip/palate
____ Hyperbilirubinemia ("jaundice" biliruben levels requiring a blood exchange transfusion)
____ Ototoxic medications for more than 5 days (gentamycin, vancomycin, lasix, etc.)
____ Intracranial bleed and/or other CNS abnormality
____ Bacterial Meningitis
____ Congenital Perinatal Infections (herpes, HIV, syphilis, rubella, CMV, toxoplasmosis)
____ Other, please explain: _____

7. Does your child have a history of head trauma? ____ *Yes* ____ *No*
(Birth trauma, skull fracture, concussion, unconsciousness, etc.)
If *YES*, please describe, including dates and circumstances: _____
_____
_____

8. Does your child have a history of other health problems? ____ *Yes* ____ *No*
(Diabetes, heart problems, kidney disease, thyroid problems, etc.)
If *YES*, please describe:_____
_____

9. Is your child currently taking medications? ____ *Yes* ____ *No*
If *YES*, what are they taking and why? _____
_____

10. A. Does your child have frequent ear infections? ____ *Yes* ____ *No*
B. If *YES*, which ear? ____ Right ____ Left ____ Both
C. At what age did they first occur? _____
D. How often do they occur? _____
E. What are the symptoms? _____
F. How have they been treated? _____

11. Do you feel that your child's speech is delayed? ____ *Yes* ____ *No*
If *YES*, please describe why: _____
_____

12. Are there any other developmental concerns? ____ *Yes* ____ *No*
If *YES*, please describe: _____
_____

13. Other information you'd like us to know? _____
_____
_____