NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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Infant / Child History – Birth to age 12 (Page 1 of 2)

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)
   ___ Responds when called
   ___ 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 at *a young age*? ___ *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, lack of oxygen, history of NICU stay 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)

Infant / Child History – Birth to age 12

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
   - ___ Craniofacial or skeletal abnormalities (slight to obvious malformations of the head, neck, mouth, ears, etc.)
   - ___ Cleft lip/palate
   - ___ Hyperbilirubinemia ("jaundice" bilirubin levels requiring a blood exchange transfusion)
   - ___ Ototoxic medications for more than 24 hours (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. Is there a history of head trauma? (Birth trauma, skull fracture, concussion, unconsciousness, etc.) ___ *Yes* ___ *No*
   If *YES*, please describe, including dates and circumstances: _____
   _____
   _____

8. Is there a history of health problems? (Diabetes, heart problems, kidney disease, thyroid problems, etc.) ___ *Yes* ___ *No*
   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 many within the last 12 months? _____
    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 or behavioral concerns? ___ *Yes* ___ *No*
    If *YES*, please describe: _____
    _____

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