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: _____ Sex: ◯ Female ◯ Male
(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, doorbell, 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*, please describe their relationship to your child:
   _____

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

5.a. Was there anything unusual about the delivery? *(Long labor, forceps/assisted delivery, cesarean section, bleeding, premature membrane rupture, lack of oxygen, history of NICU stay or any other complications)* ◯ *Yes* ◯ *No*
   If *YES*, please describe:
   _____

   b. Where was the child born? (Facility, city, state):_____

   c. Did the child have a NBHS (New Born Hearing Screening)? ◯ *Yes* ◯ *No* ◯ *Unknown*

   d. What were the results of the NBHS? ◯ *Pass* ◯ *Refer* ◯ *Unknown*

(PLEASE TURN OVER FOR PAGE 2)

Infant / Child History – Birth to age 12 (Page 2 of 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
- ☐ 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*, please list what they are taking and why:

   _____

10. Does your child have frequent ear infections? ◯ *Yes* ◯ *No*
    a. If *YES*, which ear? ◯ *Left Ear* ◯ *Right Ear* ◯ *Both Ears*
    b. At what age did they first occur? _____
    c. How many within the last 12 months? _____
    d. 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:

    _____

    _____

12. Are there any other developmental or behavioral concerns? ◯ *Yes* ◯ *No*
    If *YES*, please describe:

    _____

    _____

13. Please list any other information you'd like us to know: _____

_____

_____