Pediatric Hearing History

Name _____ Date_____

Patient Date of Birth _____

Has the patient had a hearing test before? ☐ Yes ☐ No When? _____

Where? _____

Do you have any concerns regarding the patient's hearing? ☐ Yes ☐ No

If yes, Explain_____

Did the patient have a Newborn Hearing Screening OAE) at birth? ☐ Yes ☐ No

If yes, what were the results? ☐ Passed ☐ Failed ☐ Don't Know

Does the patient have any other health problems?_____

_____

Has the patient experience any of the following? (Please check)

- ☐ Ear infection (When was the last infection? _____)
- ☐ Ear pain
- ☐ Drainage from the ear
- ☐ Popping or fullness in the ear
- ☐ Dizziness or Vertigo

Has the patient been seen by an Ear, Nose, and Throat Doctor? ☐ Yes ☐ No

Who? _____

Has the patient ever had ear tubes? ☐ Yes ☐ No Are they currently in place? ☐ Yes ☐ No

If yes, Who did the procedure? _____ When? _____

Does the patient have any noisy hobbies? ☐ Yes ☐ No Describe_____

Does anyone in the patient's family have a hearing loss? ☐ Yes ☐ No

Who? _____

Thank you for taking the time to complete this form.
It will help your Audiologist better meet your hearing healthcare needs.