

CHILD HISTORY

Last updated on: 3/30/2021

Name (last, first, MI): _____

Date: _____

DOB: _____

Reason for visit: _____

Do you have concerns about your child's hearing? _____

Does school/daycare provider have c/o child's hearing? _____

Does your child have any of the following?

Hx of ear infections _____

ENT consults or treatment _____

Speech/Lang. delay Yes/No expressive _____ receptive _____ Tx: _____

Age appropriate behavior _____ Family Hx of HL _____

Problems with:

Heart _____ Kidneys _____ Vision/Eyes _____

Lead poisoning _____ Head Trauma/Seizures _____ Allergies _____

Serious Illnesses/Meningitis/High Fevers _____

Hospitalizations/Surgeries _____

Followed by other specialists? _____

Birth Information:

Place _____ Full-term/Premature(<32wks) _____

Birth weight (<1500g or 3.3lbs) _____ UNHS _____

Treatments/complications: *Hyperbilirubinemia (>20 mg/dL), ECMO, Mechanical vent (>10 days), Perinatal asphyxia, Pulmonary hypertension* _____

Pregnancy: (*Infections: CMV, Herpes, Rubella, Syphilis or Toxoplasmosis?*) _____

Other High risk factors per MDPH: *Atresia/microtia, preauricular pits/tags, cleft lip, cleft palate, Trisomy 21, CHARGE association, bacterial meningitis, chemotherapy/ototoxic medication, syndromes associated with hearing loss, and other risks*

Notes: _____

Thank you for
your input

Audiologist _____