Complete Hearing
4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | complete-hearing.com

1-5 years

Patient name: _____ Date: _____

Preferred first name: _____ Birthdate: _____ Gender: female / male

Parents / Guardians: _____

Marital status: single / married / divorced / widowed / partner

Pediatrician / Primary Care Physician (PCP):_____

Name of Business & Address of PCP: _____

_____

_____

Did the patient pass their *Newborn Hearing Screening*? ☐Yes ☐No

Other than the *Newborn Hearing Screening*, has the patient's hearing been previously tested? ☐Yes ☐No

If yes, please list when and the results, if known: _____

What are your hearing concerns for the patient? _____

_____

Does the patient consistently respond to your voice? ☐Yes ☐No

Does the patient respond to loud noise? ☐Yes ☐No

When sound is present, does the patient search to find the sound? ☐Yes ☐No

Is there a family history of early onset hearing loss? (Before the age of 30) ☐Yes ☐No

If so, please state how related & at what age loss occurred: _____

_____

Were there any complications with the pregnancy? (To include but not be limited to: prematurity, prescribed medications, recreational drug use)

_____

_____

During & after birth, were there any complications? (To include but not be limited to: preterm labor, umbilical cord issues, breathing or feeding difficulties, incubator/medication needs, jaundice)

_____

_____

List all medical history regarding the patient's ears: (To include but not be limited to: Ear Pain/Infection/Disease/Surgery, Wax, Itchy Ears)

_____

_____

If ear infections have occurred, how have they been treated? ☐Antibiotics ☐Pressure Equalizing Tubes (How many sets? _____)

Please continue on other side→

List all medications the patient currently takes & the reason: _____

_____

List all significant medical history: (To include but not be limited to: Autism, Attention Deficit Disorder, hospitalizations, surgeries)

_____

_____

Any past or current physical development concerns? ☐Yes ☐No

If yes, please explain: (To include but not be limited to: balance issues, falls, uncoordinated or clumsy actions) _____

_____

At what age did the patient walk? _____

Does the patient play / interact well with other children? ☐Yes ☐No

Are there any concerns that the patient has attention / concentration difficulties? ☐Yes ☐No

Do you have any concerns about the patient's speech and language development? ☐Yes ☐No

If yes, please explain: _____

_____

List the age the patient: Followed simple directions_____ Say their first word_____ Put two words together_____

How many words does the patient use? _____

Has the patient's speech been evaluated by a *Speech Pathologist*? ☐Yes ☐No

If so, is the patient currently receiving speech therapy services? ☐Yes ☐No

Is the patient service connected with any other special education service(s)? ☐Yes ☐No

If yes, please explain: _____

_____

Any additional concerns / comments:_____

_____

_____