

Complete Hearing



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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: _____

