Alexandria Hearing Centers
Massa & Associates

Pediatric Patient History

Patient name: _____ Date of birth: _____

Please **circle** the appropriate response and describe as indicated.

1. Did your child pass their newborn hearing screening at the hospital? No Yes Unsure

2. Is there a history of hearing loss in the family? No Yes Unsure
   If yes, please explain: _____

3. Which languages are spoken at home? _____

4. Does your child receive any special services (i.e., speech therapy, physical therapy, occupational therapy, learning disability, bilingual services, etc.)? No Yes Unsure

   If yes, please explain: _____

5. Are you concerned about your child's hearing? No Yes Unsure

6. Check if your child has ever had the following:
   - Ear infection
   - Ventilation tubes in eardrum
   - Excessive ear wax
   - Ear pain
   - Ringing in the ears
   - Dizziness
   - Head injury
   - Major medical problems: _____

7. Pediatrician's Name:
   _____

8. Additional notes/comments:
   _____
   _____
   _____
   _____