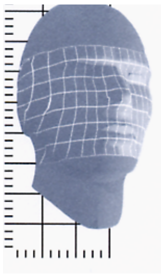

ChEARS, Inc.

Pediatric Hearing Health History

Name of child:______________________________

Date of birth: _______________________________

Accompanied by:__________________________ Relationship:_____________________

Reason for today's visit: ____

Today's date:___________________________

Birth and health history - please check all that apply:

- ❑ Full term birth
- ❑ Premature birth
- ❑ Complications during pregnancy (please specify):__________________________
- ❑ Complications during delivery:
  - ❑ Low APGAR scores
  - ❑ Other:____
- ❑ NICU stay. Please specify length of stay:_________________________________
- ❑ Child is adopted or under foster care
- ❑ Diagnosis, if any (i.e. autism, syndrome, developmental delay):_______________

Hearing history - please check all that apply:

- ❑ Passed newborn hearing screening
- ❑ Did not pass newborn hearing screening
- ❑ Did not pass hearing screening at school/pediatrician's office
- ❑ Family history of hearing loss
- ❑ Delayed speech/language development
- ❑ Child asks for frequent repetition
- ❑ Child reports noise in the ears (tinnitus)
- ❑ Child reports fullness in the ears
- ❑ History of ear infections. How many? ___________________________________
- ❑ History of ear surgery (please specify):__________________________________
- ❑ Hearing aids have been recommended by another provider
- ❑ Child currently uses hearing aids

Educational history - please check all that apply:

- ❑ Grade in school: __________________
- ❑ Name of school and school district:____________________________________
- ❑ Academic concerns (please specify):____________________________________
- ❑ Child attends speech therapy
- ❑ Concern for auditory processing disorder