Paschall Michaud Gier Robertson

Asheville Head Neck & Ear Surgeons, PA

CHILD AUDIOLOGICAL HISTORY

ID#____________
(For Office Use Only)

PATIENT INFORMATION

Legal Name: ______________________ ______________________ ______________________
(Shown on Birth Certificate) First Middle Last

Preferred Name: ______________ Date Of Birth: ____/____/____ Age: __________ Sex: M F

Birth Mother Name: ______________________ Legal Guardian Name: ______________________

Form Completed By: ______________________ Relationship to Patient: ______________________

Did the patient pass newborn hearing screen?: ☐ Left Ear ☐ Right Ear

Any complications during pregnancy or delivery? Did patient spend time in NICU? Explain: ______________________

Was patient full term? ☐ Yes ☐ No If No, how many weeks: _____ Name of Hospital: ______________

Describe hearing problem: ______________________

Does patient:

- ☐ Respond to their name
- ☐ Prefer TV to be very loud
- ☐ Respond to sounds consistently
- ☐ Hear better in one ear than the other
- ☐ Respond only to loud sounds
- ☐ Respond to the doorbell
- ☐ Hear better some days than others
- ☐ Look at the speaker's face
- ☐ Respond to the telephone
- ☐ Respond to automobile sounds
- ☐ Respond better to sound with visual stimulus than without

Any family member with childhood hearing loss? ☐ Yes ☐ No

Has the patient ever worn hearing aids? ☐ Yes ☐ No If Yes, What type?: ______________________

Has patient ever been diagnosed with:

- ☐ Ear infections
- ☐ Ear drainage
- ☐ Ear aches
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Ear tubes
- ☐ Eustachian tube dysfunction
- ☐ High fevers
- ☐ Noise exposure
- ☐ Environmental allergies
- ☐ CMV
- ☐ Speech / language delay
- ☐ Cancer
- ☐ Cleft Palate or Lip
- ☐ Cerebral Palsy
- ☐ Jaundice
- ☐ Epilepsy
- ☐ Encephalitis
- ☐ Measles
- ☐ Mumps
- ☐ Meningitis
- ☐ Microtia
- ☐ Atresia
- ☐ Down's Syndrome
- ☐ Other ______________________

Has patient ever been diagnosed with physical or mental handicaps? ______________________

Has patient ever had any severe head injuries? ______________________

Does patient attend school? ☐ Yes ☐ No If yes, please list: ______________________

Is patient receiving any related rehabilitative services? ______________________

- ☐ CDSA
- ☐ Beginnings
- ☐ Early Intervention
- ☐ Other ______________________

Any further pertinent history? ______________________