ADVANCED HEARING
AND BALANCE CENTER

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/11

Reason for Today's visit _____

Referred by _____

Child lives with: ___ both parents ___ Mother ___ Father ___ other

Names and ages of any other children at home: _____

Name and Address of Child's School, Preschool or Child Care Setting

_____

GENERAL MEDICAL

1. Do you have any medical concerns about your child? YES NO
If yes, briefly explain: _____

_____

2. Please check if your child has had any of the following:

Ear infections	❑	Meningitis	❑	Seizures	❑
Ear surgery	❑	Measles	❑	Kidney problems	❑
Hospitalization	❑	Mumps	❑	Vision problems	❑
Head trauma/injury	❑	Chicken pox	❑	Allergies	❑
Noise exposure (e.g. farm equipment, loud music)			❑	Asthma	❑

Briefly explain any you checked: _____

_____

3. Please list any prescription or over-the-counter medications your child is taking and for what reason(s): _____

_____

4. Has your child ever experienced **head trauma**? YES NO

5. Has your child ever had surgery on his/her ear(s), nose, or throat? YES NO

HEARING (*Please fill in the blanks or circle where appropriate*)

1. Do you have any concerns about your child's hearing? YES NO
If yes, briefly explain: _____

2. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30? YES NO If yes, who? _____

4. Does your child consistently respond to your voice? YES NO

5. Does your child respond to loud noises? YES NO

6. When sound is present or someone is speaking, does your child search to find where the sound is coming from? YES NO

7. Does your child respond to sounds from other rooms? YES NO

8. Does your child enjoy listening to music? YES NO

9. Has your child's hearing ever been tested? YES NO
If yes, please list by whom, when and results _____

10. Does your child wear hearing aid(s)? YES NO
If yes, when was your child first fit?_____

11. Does your child receive preferential classroom seating? YES NO

Pregnancy And Birth History *(please circle YES or NO)*

1. Was the pregnancy abnormal in any way? YES NO

2. Was the delivery abnormal in any way? YES NO

3. Was the delivery premature? YES NO

4. Did the mother have any illness during the pregnancy? YES NO

5. Did the mother take any medication during the pregnancy? YES NO

6. After birth, did your child have:
   - Breathing difficulties? YES NO
   - Require an incubator? YES NO
   - Any head, neck or ear abnormalities? YES NO
   - Feeding problems? YES NO
   - Surgery? YES NO
   - Any infections requiring medication? YES NO
   - Treatment for jaundice (yellow coloration of the skin)? YES NO

If yes to any of the above, briefly explain: _____
_____
_____