Curran/Davies/Dickens
Paschall/Patel/Watson

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
- ☐ Respond to sounds consistently
- ☐ Respond only to loud sounds
- ☐ Hear better some days than others
- ☐ Respond to the telephone
- ☐ Prefer TV to be very loud
- ☐ Hear better in one ear than the other
- ☐ Respond to the doorbell
- ☐ Look at the speaker's face
- ☐ 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	☐ Noise exposure	☐ Epilepsy
☐ Ear drainage	☐ Environmental allergies	☐ Encephalitis
☐ Ear aches	☐ CMV	☐ Measles
☐ Ringing in the ears	☐ Speech / language delay	☐ Mumps
☐ Dizziness	☐ Cancer	☐ Meningitis
☐ Ear tubes	☐ Cleft Palate or Lip	☐ Microtia
☐ Eustachian tube dysfunction	☐ Cerebral Palsy	☐ Atresia
☐ High fevers	☐ Jaundice	☐ 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? _____

_____

_____