Valley Vision Associates

Leo Oltman, H.I.S.

Hearing History (Newborn to 18 years)

Instructions: Please answer the following questions as completely as possible

Date:____________________

Child's Name: ____Birth Date:________________

Primary Care Practitioner: ____________________ Referring Source:________________________________

Your Name:________________________________ Relationship:__________________________________

If Guardian or Foster Parent, how long has this child been in your care? ______________________________

What concerns do you, your child's health care provider or school personnel have about your child's hearing?

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Birth History:

Were there any medical complications during the pregnancy or birth of your child? ....Y / N

Did your child pass his/her new born hearing screening? ....Y / N

Health History:

Has your child had any serious illness or injuries since birth? ....Y / N

If yes, please describe. ____

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Does your child complain of ringing in the ears? ....Y / N

Does your child have problems with his/her balance? ....Y / N

Has your child had ear infections? ....Y / N

Has your child had ventilation (ear) tubes placed? ....Y / N

Has your child had any other type of ear surgery? ....Y / N

Family History:

Are there any family members who have or had a hearing loss at a young age? ....Y / N

If so, how is this individual related to your child? ____

Noise Exposure:

Has your child ever been exposed to any loud noises in the past? ....Y / N

If yes, please circle the type. Firearms Snowmobiles Motorcycles Fireworks

Speech/Language Development:

Are there concerns about your child's speech development? ....Y / N

Has your child ever had a speech and language evaluation? ....Y / N

Is your child currently in speech therapy or has he/she been in the past? ....Y / N

Amplification

Does your child have amplification in: Right / Left (Please circle)

Dispenser: ____

How old are your child's present aid(s)?_____________ How does your child hear with their hearing aid(s)?

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Parent/Guardian Signature:________________________________