Hearing Evaluation Services of Buffalo, Inc.

It's Good to Hear

Pediatric Hearing Health History

Child's Name: ______________________ Date of Birth: ______________

Mother's Name: ______________ Father's Name: ______________

Siblings (Names & Ages): ______________________________

Info Provided By: ______________ Relationship to Child: ______________

Primary Care Physician: ______________________________

Who referred you to our office: ______________________________

What is your chief concern: ☐ Hearing ☐ Speech/Language Development ☐ Other: ________

Is there a family history of hearing loss (if yes, who): ______________________

Does your child currently receive speech therapy: _____ If yes: how many times per week: ______

Pregnancy History

Complications during pregnancy: ______________________________

Medications/drugs used during pregnancy: ______________________________

Alcohol used during pregnancy (how often): ______________________________

Birth History

Birth weight: __________ How many weeks early/late: ______________

Was your child in intensive care? ________ Reason and how long: ______________

Newborn Hearing Screening: ☐ Pass ☐ Fail ☐ Don't Recall

Other delivery problems: ______________________________

Medical History

Please check all that apply to your child and explain below:

☐ High Fever ☐ Seizures/Convulsions ☐ Past/Present Medications: ______________

☐ Hospitalizations/Surgeries: ______________________________

Medical Conditions: ______________________________

____

Development and Social History

Does your child: ☐ interact well with others his/her age ☐ have behavioral problems

What age did your child: Sit Alone: ________ Walk Alone: ________ Use 1st word: ________

Use 1st Sentence: Describe any slowly developing behavior:

(Please complete back of form).

Amherst
4600 Main St., Ste. 201
Amherst, NY 14226

Orchard Park
4063 N. Buffalo Rd., Ste. 3
Orchard Park, NY 14127

www.HESofBuffalo.org
(716) 833-4488

Tonawanda
2545 Sheridan Dr., Ste. 5
Tonawanda, NY 14150

Williamsville
2733 Wehrle Dr., Ste. 200
Williamsville, NY 14221

Keeping your child's age in mind, please rate the following:

Motor coordination and balance	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to keep attention on activity	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to follow directions	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Ability to speak clearly	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Hearing History

Do you now or have you ever had any concerns about your child's hearing? ☐ Yes ☐ No

Does your child have a permanent hearing loss that you are aware of? ☐ Yes ☐ No

If so, please describe (ex. 1 ear only, can't hear high pitches, etc.) ______________________

Has a teacher ever expressed concern about your child's hearing? ☐ Yes ☐ No

Does your child respond to sound consistently? ☐ Yes ☐ No

Do you feel you need to repeat things for your child in order to be understood? ☐ Yes ☐ No

Does your child say "What?" or "Huh?" frequently? ☐ Yes ☐ No

Do you need to raise your voice for your child to respond? ☐ Yes ☐ No

Does your child sit close to the TV or turn up the volume? ☐ Yes ☐ No

Does your child appear to have difficulty understanding speech in background noise? ☐ Yes ☐ No

Ear History

Has your child ever had an ear infection? ☐ Yes ☐ No If yes, how many: __________

When was your child's most recent ear infection? ______________________

Has your child ever been treated with antibiotics for an ear infection? ☐ Yes ☐ No

Is your child currently on antibiotics for treatment or prevention of ear infections? ☐ Yes ☐ No

Has your doctor ever observed fluid behind your child's eardrums? ☐ Yes ☐ No

Has your child ever seen an Ear, Nose, & Throat (ENT/Otolaryngologist) specialist? ☐ Yes ☐ No

Has your child ever received pressure equalizing tubes for chronic ear infections? ☐ Yes ☐ No

How many sets of tubes? ______________ At what ages? ______________________

Does your child have frequent colds, allergies, or congestions? ☐ Yes ☐ No

Other Important Information Not Provided Above

____

____

Signature of Person
Providing Information: ______________________________ Date: ______________

Please bring this completed form to your appointment.