ChEARS, Inc.

Pediatric Hearing Health History

Name of child:_____

Date of birth: _____

Accompanied by:_____ Relationship:_____

Reason for today's visit: _____

Today's date:_____

Birth and health history - please check all that apply:

- ❑ Full term birth
- ❑ Premature birth
- ❑ Complications during pregnancy (please specify):_____
- ❑ Complications during delivery:
  - ❑ Low APGAR scores
  - ❑ Other:_____
- ❑ NICU stay. Please specify length of stay:_____
- ❑ Child is adopted or under foster care
- ❑ Diagnosis, if any (i.e. autism, syndrome, developmental delay):_____

Hearing history - please check all that apply:

- ❑ Passed newborn hearing screening
- ❑ Did not pass newborn hearing screening
- ❑ Did not pass hearing screening at school/pediatrician's office
- ❑ Family history of hearing loss
- ❑ Delayed speech/language development
- ❑ Child asks for frequent repetition
- ❑ Child reports noise in the ears (tinnitus)
- ❑ Child reports fullness in the ears
- ❑ History of ear infections. How many? _____
- ❑ History of ear surgery (please specify):_____
- ❑ Hearing aids have been recommended by another provider
- ❑ Child currently uses hearing aids

Educational history - please check all that apply:

- ❑ Grade in school: _____
- ❑ Name of school and school district:_____
- ❑ Academic concerns (please specify):_____
- ❑ Child attends speech therapy
- ❑ Concern for auditory processing disorder