Paschall Michaud Gier Robertson

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? _____

_____

_____