TINY EARS
Pediatric Division of Harmony Hearing & Audiology

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CHILD PATIENT HISTORY

Name_____ Date _____

What is the **primary purpose** of today's visit? ☐ Hearing Concerns ☐ Speech/Language Concerns ☐ Newborn Hearing Screening ☐ Other _____

Do you suspect your child has **hearing difficulties**? ☐ Yes ☐ No If so, for how long? _____

Is there any **family history** of hearing problems? ☐ Yes ☐ No If so, who? _____

Is there any **family history** of learning problems? ☐ Yes ☐ No If so, who?_____

Has your child recently experienced any of the following?

☐ Sudden Change in Hearing ☐ Ear Pain ☐ Ear Pressure/Fullness ☐ Ear Drainage ☐ Sensitivity to loud sound
☐ Other _____

Has your child ever been treated for any **medical issues involving the ears**? ☐ Yes ☐ No _____

Does your child currently take **any prescription medications**? ☐ Yes ☐ No _____

Does your child have any **significant health problems**? ☐ Yes ☐ No _____

_____

Does your child receive **supplemental services** in school? ☐ Yes ☐ No

Has your child experienced any **delays** in the following?: Crawling/Walking?: ☐ Yes ☐ No

Speech/Language? ☐ Yes ☐ No

At **which hospital** was your child born? _____

Were there any **complications at birth**? ☐ Yes ☐ No _____

Did your child spend any **time in the NICU**? ☐ Yes ☐ No If so, how long? _____

Did your child pass the newborn **hearing screening** in the hospital? ☐ Yes ☐ No ☐ Unsure ☐ Not tested

Additional Comments_____