happy ears HEARING CENTER

8877 W Union Hills Dr, Ste 350 | Peoria, AZ 85382
15015 W Bell Rd, Ste 101 | Surprise, AZ 85374
6116 E Arbor Ave, Ste 110 | Mesa, AZ 85206

CHILD HEARING CASE HISTORY – CONFIDENTIAL INFORMATION

Please complete front and back pages

Child's Full Name _____ Date of Birth _____

Person answering these questions: _____ Relationship to Child: _____

Who referred you to Happy Ears? _____ Today's Date: _____

Name of Child's Pediatrician: _____

Birth History

YES	NO	
☐	☐	Was the child full term?
☐	☐	Prematurity? Gestational Age at Birth: _____weeks
☐	☐	Jaundice
☐	☐	Complications during pregnancy/deliver. If yes, please describe_____ _____ _____
☐	☐	Medical Attention following birth. If yes, please describe _____ _____
☐	☐	Did the child require an extended NICU stay at birth? If yes, describe _____ _____
☐	☐	Did any family member smoke cigarettes in the household during pregnancy?
☐	☐	Was the child exposed to drugs in utero? If yes, please describe _____ _____

Medical History

Does your child present with any of the following medical conditions?

- ☐ Head trauma/injury
- ☐ Seizure disorders
- ☐ Visual problems
- ☐ Syndrome _____
- ☐ Other _____

Does your child have any of the following diagnoses?

- ☐ ADHD/ADD/Attention difficulties
- ☐ Anxiety and/or depression
- ☐ Autism/PDD/Asperger's Disorder
- ☐ Learning Disability
- ☐ Language Disorder/Articulation Disorder _____
- ☐ Hearing Loss

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

Is your child currently receiving any outpatient therapy services? ☐ **YES** ☐ **NO**

- ☐ Early Intervention Services _____
- ☐ Speech/Language Therapy
- ☐ OT
- ☐ PT
- ☐ Other: _____

Please check "YES" or "NO" to the following Questions

YES	NO	
☐	☐	Has the child had any problems with ear infections? Number of infections per year _____
☐	☐	Has there been any drainage from the ears?
☐	☐	Has the child ever had tubes? Number of sets _____
☐	☐	Ear Surgery? Date of surgery(s) _____
☐	☐	Was the child full-term?
☐	☐	Did the child's mother have any kind of illness or medical problems during her pregnancy? If Yes, please describe: _____
☐	☐	Did the child's mother take any medications during her pregnancy? If Yes, please list medications: _____
☐	☐	Was the child born with or has the child developed any medical problems? If Yes, please describe: _____ _____ _____
☐	☐	Did the child pass the newborn hearing screening? If no, describe_____ _____
☐	☐	Does the child have a speech problem? Please describe: _____
☐	☐	Does the child have a hearing problem? Please describe: _____
☐	☐	Do any of the child's family members have a hearing problem? If yes, please describe: _____
☐	☐	Do any family members wear hearing aids or use cochlear implants? If yes, please describe: _____
☐	☐	Does the child wear a hearing aid? If yes, when was it purchased? _____ What is the make and model? _____ Who fit their hearing aids on them? _____
☐	☐	Does the child frequently turn the TV or radio up too loud?
☐	☐	Does the child frequently ask for things to be repeated?
☐	☐	Does the child seem inattentive or withdrawn at home or at school?

Answer the following questions if the child is 4 years of age or younger.

YES	NO	
☐	☐	When the child is sleeping, do sudden noises awaken him/her momentarily?
☐	☐	Does the child cry at very loud noises?
☐	☐	Does the child ever jump or startle to sudden loud noise?
☐	☐	Did the child babble around 5 to 6 months of age?
☐	☐	Did the child turn directly to sounds or voices that were out of his/her sight at 7 months of age?
☐	☐	Did the child look for sounds behind him/her at 13 months of age?
☐	☐	Did the child begin to imitate some sounds at 9 to 13 months of age?
☐	☐	Does the child hear you when you call them from the other room?

Answer the following questions if the child is school-aged (5 years of age and older)

☐	☐	Is the child having problems with his/her schoolwork?
☐	☐	Are there any problems with spelling, phonics, or English?
☐	☐	Is the child able to hear when there is background noise?
☐	☐	Is the child able to discriminate between words?
☐	☐	Is the child able to discriminate words in a noisy environment?
☐	☐	Is the child able to remember a series of numbers, words, or sentences in order?
☐	☐	Is the child able to correctly follow a series of directions?
☐	☐	Does the child confuse the order or words or syllables, such as “cakecup” for “cupcake”?
☐	☐	Is the child able to remember the alphabet, days of the week, months of the year?
☐	☐	Has there been a history of divorce or separation in this family in recent months?

Check all that apply:

YES	**NO**	
☐	☐	Frequent Colds
☐	☐	Tonsillitis
☐	☐	Tonsils/adenoids removed
☐	☐	Convulsions or seizures
☐	☐	Meningitis
☐	☐	Measles
☐	☐	Mumps
☐	☐	Heart Problems
☐	☐	Encephalitis
☐	☐	Chicken Pox
☐	☐	High Fever

When was your Child’s last hearing screening or evaluation?
Date: _____ Results: _____

Please explain the reason for the referral and concerns you have about your child’s hearing:
_____
_____
_____
_____
_____

Name of person filling out this form: _____Date: _____
Relationship to child: _____