DeFatta ENT
FACIAL PLASTIC SURGERY

Audiology-Pediatrics

Name: ______________________________

DOB: ______________________________

Hearing Health History

Is there a family history of hearing loss? ☐ Yes ☐ No

If yes, who? ____

Has your child recently had any ear pain? ☐ Yes ☐ No

Has your child recently had any ear drainage? ☐ Yes ☐ No

Has your child had any pressure in their ears? ☐ Yes ☐ No

Has your child had ringing/buzzing in their ears? ☐ No ☐ Right ☐ Left ☐ Both

Does your child fall or lose balance easily? ☐ Yes ☐ No

Explain: ____

Does your child have a history of ear infections/ear surgery? ☐ Yes ☐ No

Does your child have a history of noise exposure? ☐ Yes ☐ No

Does your child respond to loud sounds? ☐ Yes ☐ No

Do you have concerns regarding your child's speech? ☐ Yes ☐ No

Has your child had a hearing test done recently? ☐ Yes When/Where:________________ ☐ No

School Information: _______________________ Grade: _________ Teacher: ___________________________

Birth/Pregancy History

Any birth or pregnancy complications? ☐ Yes ☐ No

If yes, please explain: ____________________________________ Length of pregnancy: ______________

Did your child have a stay in the NICU? ☐ Yes ☐ No Length of stay? ___________

Please check any of the conditions that occurred during pregnancy:

☐ Rh incompatibility ☐ Substance abuse ☐ Alcohol abuse ☐ CMV ☐ Lack of oxygen ☐ Infections

☐ Rubella/German measles ☐ Communicable diseases ☐ Venereal disease ☐ Toxoplasmosis

General Health

Please check all that apply and list date of occurrence:

☐ Measles ☐ Tonsillitis ☐ Chicken pox ☐ Allergies ☐ Mumps ☐ Frequent colds ☐ Scarlet fever

☐ ☐ ☐ ☐ ☐ ☐ ☐
Ear infections Meningitis Sinusitis Encephalitis Draining ears Seizures Flu

☐ ☐
High fevers Head injury

Any other serious illness or surgery? ____

Amplification History

Has your child ever worn hearing aids? ☐ No ☐ Right ☐ Left ☐ Both