NewSound Solutions
Helping You Listen for Life!

Terri Jo Edwards, Au.D.
150 Willow Creek Dr. Suite 103
Weatherford, TX 76085
817.550.6115 office
info@newsoundsolutions.com

Pediatric Hearing Health History

Child's Name: _____ Age:_____ Date of Birth: _____

Home Address: _____
Street City State Zip

Home Phone #: _____Cell Phone#: _____

Email Address: _____

Mother's Name: _____ Father's Name: _____

Siblings: _____ Who referred you to our office: _____

Pediatrician: _____ Phone #: _____

Info Provided By: _____ Relationship to Child: _____

Insurance Information

Primary Insurance
Subscriber's Name: _____ Date of Birth: _____

Insurance Name/ Plan Name: _____

Subscriber ID: _____ Group Number:_____

Secondary Insurance
Subscriber's Name: _____ Date of Birth: _____

Insurance Name/ Plan Name: _____

Subscriber ID: _____ Group Number:_____

What is your chief concern:
Hearing: _____ Speech/Language Development: _____ Other: _____

Is there a family history of hearing loss: Y N if yes, who: _____

Pregnancy History

Complications during pregnancy: _____
Medications/drugs used during pregnancy: _____
Alcohol used during pregnancy (how often): _____

Birth History

Birth weight: _____ How many weeks early/late: _____
Was your child in intensive care? Y N Reason and how long: _____
Newborn Hearing Screening: Pass: _____ Fail: _____ Don' t Recall: _____
Other delivery problems: _____

Medical History

Please check all that apply to your child and explain below:
High Fever: _____ Seizures/Convulsions: _____
Past/Present Medications: _____

Hospitalizations/Surgeries (including myringotomy with/without insertion of tympanostomy tubes):_____

Medical Condtions:_____

Development and Social History

Does your child: Interact well with others his/her age? Y N Have Behavioral Problems? Y N
What age did your child: Sit Alone: _____ Walk Alone: _____ Use 1st Word: _____
Use 1st Sentence: _____ Describe Any Slowly Developing Behavior: _____

Keeping your child's age in mind, please rate the following:

Motor coordination and balance:	Excellent	Good	Fair	Poor
Ability to keep attention on activity:	Excellent	Good	Fair	Poor
Ability to follow directions:	Excellent	Good	Fair	Poor
Ability to speak clearly:	Excellent	Good	Fair	Poor

Hearing History

Do you now or have you ever had any concerns about your child's hearing?	Yes	No
Does your child have a permanent hearing loss that you are aware of?	Yes	No
If yes, please describe (ex. 1 ear only, can't hear high pitches, etc.): _____		
Has a teacher ever expressed concern about your child's hearing?	Yes	No
Does your child respond to sound consistently?	Yes	No
Do you feel you need to repeat things for your child in order to be understood?	Yes	No
Does your child say "What?" or "Huh?" frequently?	Yes	No
Do you need to raise your voice for your child to respond?	Yes	No
Does your child sit close to the TV or turn up the volume?	Yes	No
Does your child appear to have difficulty understanding speech in background noise?	Yes	No

Ear History

Has your child ever had an ear infections: Yes No If yes, how many: _____

When was your child's most recent ear infection? _____

Has your child ever been treated with antibiotics for an ear infection?	Yes	No
Is your child currently on antibiotics for treatment or prevention of ear infections?	Yes	No
Has your doctor ever observed fluid behind your child's eardrums?	Yes	No
Has your child ever seen an Ear, Nose, & Throat (ENT/Otolaryngologist) specialist?	Yes	No
Has your child ever received pressure equalizing tubes for chronic ear infections?	Yes	No
How many sets of tubes? _____ At what ages? _____		
Does your child have frequent colds, allergies, or congestions?	Yes	No

Other Important Information Not Provided Above: _____

_____

_____

Signature of Person Providing Information: _____Date:_____