CHOC Children's Specialists

Pediatric Hearing Center

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Hearing History

1. Did your child (the patient) pass his/her newborn hearing screening? **(yes/no)**
2. Has your child seen an audiologist? **(yes/no)**
    a. What hearing tests were performed?
    b. What were the results of the hearing tests?
    c. Do you have a copy of your hearing results? **(yes/no)**
3. Has your child had a CT scan of his temporal bones (ears)? **(yes/no)**

Prenatal/ Perinatal History

1. Did the mother receive prenatal care throughout her pregnancy? **(yes/no)**
2. Were there any complications with the delivery? **(yes/no)**
3. Was your child premature (born earlier than expected)? **(yes/no) (how early?_____)**
4. Did your child have jaundice? **(yes/no)**
    a. If yes, are you aware as to high the level was _____, and did he/she require any exchange transfusion**(yes/no)**
5. Did you child stay in the Neonatal Intensive Care Unit? **(yes/no)**
6. Did your child need the support of a ventilator to breathe after birth, and for how long? (yes/no; _____)
7. Are you aware if your child needed any antibiotics in the hospital after birth, and any medicine to help with making urine? (yes/no) If yes, please describe_____
8. Were there any prenatal TORCH infections (Toxoplasmosis, Rubella, CMV, Herpes, Syphilis)? **(yes/no)**
    a. If so, which one? _____

Patient's Medical History

1. Do you, as parents, have any concerns about your child's hearing? (yes/no)
2. Are you concerned about your child's balance? (yes/no)
3. Has your child had meningitis? **(yes/no)**
4. Has your child had any heart problems or abnormalities in heart rhythm? arrhythmia or any cardiac problems? **(yes/no)**
5. Has your child undergone any genetic testing? **(yes/no)**
    a. If so what were the results? _____
6. Does your child have any renal (kidney) problems? **(yes/no)**
7. Does your child have any vision problems? **(yes/no)**
8. Is there any history of head injury? (yes/no)
9. Did your child get admitted to the hospital since **after** birth (yes/no), and did he/she receive any intravenous antibiotics, and/or any medicines to help make urine?

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Family History

1. Is there a history of consanguinity (are the child's parents related, i.e. brother and sister, first cousins)? **(yes/no)**
2. Is there a history of hearing loss in the family? **(yes/no)**
3. Is there a family history of ear malformations (abnormally shaped ears)? **(yes/no)**
4. Is there a family history of renal failure/kidney problems? **(yes/no)**
5. Is there a family history of vision loss or blindness? **(yes/no)**
6. Is there a family history of white forelocks or of graying of hair at an early age? **(yes/no)**
7. Is there a family history of heterochromia (different colored eyes)? **(yes/no)**
8. Is there a family history of developmental delay? **(yes/no)**
9. Is there a family history of facial asymmetry (the two sides of the face not being equal)**?** **(yes/no)**
10. Is there a family history ear pits (little openings in front of /above the ears)? **(yes/no)**
11. Is there a family history of cleft lip or palate? **(yes/no)**
12. Is there any family history of sudden death or fainting episodes? **(yes/no)**
13. Is there any family history of thyroid problems? **(yes/no)**
14. Do the parents have any hearing loss, even mild hearing loss? **(yes/no)**

Signature Relationship Date

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