CHOC Children's Specialists
Pediatric Hearing Center

Affiliated with: School of Medicine, University of California • Irvine

Gurpreet S. Ahuja, MD, FAAP
Nguyen S. Pham, MD
Kevin C. Huoh, MD, FAAP, FACS
Jay M. Bhatt, MD, FAAP
Qiu Zhong, MD
Division of Pediatric Otolaryngology

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?

1010 W. La Veta Ave., #640 Orange, CA 92868
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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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