GARY D. SCHWARTZBERG, Au.D.
Doctor of Audiology

# Pediatric Hearing Health History

Patient Name: _____ Male ☐ Female ☐ DOB: _____ Date: _____

Person Completing Form: _____ Relationship to Patient: _____

**I. Primary Concern:**

Do you feel that this child has a hearing loss? Yes ☐ No ☐

Are you concerned about this child's speech or language development? Yes ☐ No ☐

Please describe concern: _____

**II. Prenatal and Birth History:**

Length of Pregnancy: _____ Birth weight: _____ APGAR Score: _____

List any medications or drugs (including alcohol) used during pregnancy: _____

_____

Remarkable pregnancy? Yes ☐ No ☐

Mother's illness during pregnancy:

(Herpes, Toxoplasmosis, CMV, Syphilis, Rubella)? Yes ☐ No ☐

Complicated delivery? Yes ☐ No ☐

Did this child pass the newborn hearing screening: Yes ☐ No ☐

***After birth, did this child have:***

Breathing difficulties (mechanical ventilation/ECMO)? Yes ☐ No ☐

Admission to the Intensive Care Unit? Yes ☐ No ☐

Head, neck or ear abnormalities? Yes ☐ No ☐

Skin tags or pits near the ears? Yes ☐ No ☐

Jaundice (high bilirubin)? Yes ☐ No ☐

Head trauma/defect? Yes ☐ No ☐

Surgery? Yes ☐ No ☐

Diagnosis of a neurologic condition? Yes ☐ No ☐

Diagnosis or suspicion of a syndrome or other unifying disorder? Yes ☐ No ☐

Vision problems? Yes ☐ No ☐

Kidney problems? Yes ☐ No ☐

**III. Family History:**

Family members with hearing loss before age 40? Yes ☐ No ☐

If yes, age, relationship and suspected cause? _____

_____

**IV. Communication and Developmental History:**

Difficulties with pronunciation? Yes ☐ No ☐

Language development concerns? Yes ☐ No ☐

Difficulties listening or understanding conversation? Yes ☐ No ☐

Attention problems at school (if applicable)? Yes ☐ No ☐

Other developmental delays? Yes ☐ No ☐

**V. Hearing and Middle Ear History:**

Previous hearing test? Yes ☐ No ☐\

Allergies? Yes ☐ No ☐

Hazardous noise exposure? Yes ☐ No ☐

Noise in ears (tinnitus)? Yes ☐ No ☐

Balance or coordination difficulties? Yes ☐ No ☐

***Middle ear health:***

Number of ear infections: _____ At what age resolved? _____

Pressure equalization tubes placed? Yes ☐ No ☐

If yes, by whom and when? _____

History of ear pain? Yes ☐ No ☐

Please list any medications this child is currently taking: _____

_____

***General Observations:***

Child responds to environmental sounds or voices? Yes ☐ No ☐

Child startles to loud noises? Yes ☐ No ☐

Child searches to find the source of sounds? Yes ☐ No ☐

**V. Physical/General Health Conditions:**

List any physical or health conditions: _____

_____

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## Patient Information

Date: _____

Patient Name: _____ Male __ Female __
Last First MI

E-mail Address: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Birth date: _____ Age: _____ Soc. Sec. #: _____

Work Phone: _____ Employer: _____ Occupation: _____

Referred By: _____

Primary Care Physician: _____

Reason For Visit: _____

Next of Kin: _____ Relationship: _____

Emergency Contact: _____ Phone: _____

## Insurance

**Primary Insurance Coverage**

Insurance Company: _____

Subscriber: _____

Identification #: _____

Group #: _____

Address: _____

## Assignment and Release

**Please Note:** We will be happy to bill your primary insurance carrier. Please forward the appropriate information to your secondary insurance.

**Assignment and Release:** I hereby authorize Gary D. Schwartzberg, Au.D. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Gary D. Schwartzberg, Au.D. and acknowledge that I am financially responsible for any unpaid balance.

Signature of Patient or Guardian: _____ Date: _____