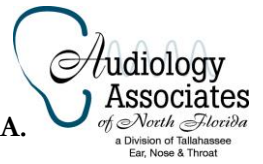




**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**  
**AUDIOLOGY ASSOCIATES OF NORTH FLORIDA**



[www.tallyent.com](http://www.tallyent.com)

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**PEDIATRIC HEARING HISTORY: 4 TO 14 YEARS**

**Child's Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

Do you have legal guardianship?

NO YES

What is the primary reason for today's visit?

\_\_\_\_\_

**ACADEMIC PERFORMANCE**

Has your child been referred to this center from a hearing screening?

NO YES

If yes, which ear failed?  Right ear  Left ear  Both

What grade is your child in at school? \_\_\_\_\_

Has your child ever repeated a grade?

NO YES

If YES, which grade? \_\_\_\_\_

Has your child's teacher expressed concern regarding his/her hearing ability?

NO YES

Overall academic performance: GOOD FAIR BELOW AVERAGE

**MEDICAL HISTORY**

Is there a family history of hearing loss: One or more blood relatives of the child had permanent hearing loss in early childhood?

NO YES

If yes, Who?  parent,  grandparent,  aunt,  uncle,  
 child's first cousin,  brother,  sister.

Child's Mother's or Father's family? \_\_\_\_\_

Has your child been hospitalized since birth?

NO YES

If yes, when? \_\_\_\_\_ why? \_\_\_\_\_

Has your child required IV antibiotics or chemotherapy?

NO YES

Has your child had an infection such as meningitis, mumps, or measles, MRSA, or RSV?

NO YES

Has your child ever had a fever in excess of 104°?

NO YES

Has your child experienced head trauma?

NO YES

(i.e. a serious fall causing a concussion or skull fracture)

Has your child been diagnosed with a specific syndrome or disorder?

NO YES

(i.e. Down Syndrome, cleft palate, Autism Spectrum Disorder) Specify: \_\_\_\_\_

Has your child had more than 4 ear infections in the past 12 months? NO YES  
 Date of the last ear infection? \_\_\_\_\_

Has your child had tubes? If yes, when? \_\_\_\_\_ NO YES

Has your child complained of ear fullness/pressure? NO YES

Does your child complain of ringing/noises in ears? NO YES  
 List any current medical conditions your child has been diagnosed with: \_\_\_\_\_

List any medicine your child is currently taking: \_\_\_\_\_

List any allergies your child has: \_\_\_\_\_

**SURGICAL HISTORY**

List any previous surgeries your child has undergone: \_\_\_\_\_

**SPEECH, LANGUAGE AND AUDITORY DEVELOPMENT**

Do you have any concern regarding your child’s speech and language development? NO YES  
 If yes, what is your primary concern? \_\_\_\_\_  
 \_\_\_\_\_

Is your child currently or has your child ever received speech and language therapy? NO YES  
 Where? \_\_\_\_\_  
 What Length of Time? \_\_\_\_\_  
 How Often? \_\_\_\_\_

Do you have any concerns regarding your child’s hearing ability? NO YES

Has your child ever expressed concern regarding his/her hearing? NO YES

Is your child receiving any other type of therapy or services? NO YES  
 If yes, please list: \_\_\_\_\_

Has your child ever been exposed to excessive noise (gun shot, explosion, NO YES  
 loud music, car racing, fireworks, etc...)?

Please list anything else you believe would be helpful for us to know when assessing your child?  
 \_\_\_\_\_  
 \_\_\_\_\_

How Did You Hear About Our Center? FRIEND / DOCTOR REFERRAL / NEWSPAPER / TV AD / RADIO / SEMINAR / TELEPHONE BOOK / OTHER: \_\_\_\_\_

**I have completed this form and to the best of my knowledge it is accurate. I understand that this document will be used for medical decision making.**

**Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**