


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Pediatric Hearing Health Assessment

Date _____ /_____ /_____

Name _____

Date of Birth _____ Age _____ Pronouns _____

School _____ Grade _____

Native Language _____ Primary Language _____

Mother's Name _____ Father's Name _____

Address _____ Address (if different) _____

_____

Phone _____ Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email _____ Email _____

Person Completing Form _____

Birth Hospital _____ Pediatrician's Name _____

Referred by _____

Insurance:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Subscriber Phone Number & Address _____

What are your concerns about your child's hearing? _____

_____

When was the hearing loss first noticed? _____

Has your child's hearing been tested before? (including newborn infant screening) ☐ Yes ☐ No

If YES, when? Where? _____

Results _____

Is there a family history of childhood hearing loss? ☐ Yes ☐ No

If YES, relationship to child _____

Can you get your child's attention by calling his/her name? ☐ Yes ☐ No

Does your child understand what you say? ☐ Yes ☐ No

Does your child follow directions correctly? ☐ Yes ☐ No

Do you have concerns about your child's speech? ☐ Yes ☐ No

If YES, explain _____

Are you concerned about how your child is doing in school? ☐ Yes ☐ No

If YES, explain _____

School _____ Teacher _____

PRENATAL HISTORY

Was the mother exposed to viral a disease during pregnancy? ☐ Yes ☐ No
If YES, what? _____

Were any drugs/medications taken during pregnancy? ☐ Yes ☐ No
If YES, what? _____

Any maternal illness during pregnancy? (e.g., Rh incompatibility, gestational, diabetes, blood transfusions, etc.) ☐ Yes ☐ No
If YES, what? _____

BIRTH HISTORY

Was the child full-term _____ or premature _____ Birth weight _____

Were there any complications? ☐ Yes ☐ No
If YES, what? _____

Were there any breathing problems? ☐ Yes ☐ No
If YES, what? _____

Any known or suspected syndromes? ☐ Yes ☐ No
If YES, what? _____

Were there any required medications (including antibiotics)? ☐ Yes ☐ No
If YES, please list: _____

Was the child placed in intensive care? ☐ Yes ☐ No
If YES, how long? _____

INFANT/CHILDHOOD HISTORY

At what age did your child: Sit alone _____ Crawl _____ Walk _____ Use first words _____ Sentences _____

Is your child currently taking any medication? ☐ Yes ☐ No
If YES, what for? _____

Has your child ever been hospitalized? ☐ Yes ☐ No
If YES, what for? _____

History of ear infections? ☐ Yes ☐ No
If YES, how many per year? _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING

Meningitis	☐ Yes ☐ No Age _____		Tonsillectomy/Adenoidectomy	☐ Yes ☐ No Age _____	
Measles	☐ Yes ☐ No Age _____		Learning Difficulties	☐ Yes ☐ No Age _____	
Rubella	☐ Yes ☐ No Age _____		Balance/Coordination Difficulties	☐ Yes ☐ No Age _____	
Cytomegalovirus	☐ Yes ☐ No Age _____		Attention Deficit Disorder	☐ Yes ☐ No Age _____	
Chickenpox	☐ Yes ☐ No Age _____		Toxoplasmosis	☐ Yes ☐ No Age _____	
Encephalitis	☐ Yes ☐ No Age _____		Syphilis	☐ Yes ☐ No Age _____	
Pneumonia	☐ Yes ☐ No Age _____		Herpes	☐ Yes ☐ No Age _____	
Diabetes	☐ Yes ☐ No Age _____		Jaundice	☐ Yes ☐ No Age _____	
High Fevers (+104)	☐ Yes ☐ No Age _____		Mumps	☐ Yes ☐ No Age _____	
Frequent Colds	☐ Yes ☐ No Age _____		Allergies	☐ Yes ☐ No Age _____	
Allergies	☐ Yes ☐ No Age _____		Blood Transfusions	☐ Yes ☐ No Age _____	
Seizures	☐ Yes ☐ No Age _____		Severe Injuries or Falls	☐ Yes ☐ No Age _____	
Vision Disorder	☐ Yes ☐ No Age _____		Whooping Cough	☐ Yes ☐ No Age _____	
Tubes in Ears	☐ Yes ☐ No Age _____		Other _____		

LIST ANY INFORMATION NOT NOTED ABOVE WHICH YOU FEEL WE SHOULD BE AWARE OF: