HEARING ASSOCIATES, INC.

18433 ROSCOE BLVD. STE. 204
NORTHRIDGE, CA 91325
AUDIOLOGY & HEARING AID DISPENSING

PEDIATRIC EVALUATION & MANAGEMENT RELEVANT HISTORY

PATIENT NAME (last)_____ (first) _____

DATE Of BIRTH: _____ AGE: _____ DATE: _____

HEARING CASE HISTORY	YES	NO	OFFICE USE ONLY: AUDIOLOGIST
Does the child have a known hearing loss?			
Does the child have suspected hearing loss?			
Is there family history of hearing loss?			
Is the child responsive to speech & environmental sounds?			
Does the child have any speech or language delays?			
Does the child have any developmental delays?			
Has the child had past or recent head injury or ear surgery?			
Has the child had ear infections? If so, how frequent?			
Did the mother have an abnormal pregnancy, birth, & delivery?			
Did the child have abnormal status at birth?			
Was the child's birth weight less than 3lbs and 5oz?			
Has the child had any childhood illnesses or traumas?			
Did the child fail a hearing screening test?			
Is the child currently on any medication(s)/antibiotic(s)?			
Does the child have any allergies?			
Has the child had any surgeries? (Head, neck, ears, eyes, throat)			HA CANDIDATE: ___ YES ___ NO

Immediate Complaint/Primary Concern:

For Office Use Only

SUMMARY DETAILS:

Discussed test results & speech audiogram w/ parent?			

CONCLUSIONS/IMPRESSION: SNHL CHL MIXED HL AD AS AU Degree:
SNHL CHL MIXED HL AD AS Degree:

Rx: ___ Medical &/or ENT follow up ____ Hearing Aid Evaluation ____ ABR ____VNG ____ Months Retest
OTHER: