

Hearing Health History

For use with KBH screens for children 5 years of age and older.

Children who have had multiple ear infections and periods of hearing loss are more likely to have language, vocabulary, and listening difficulties. Some history is beneficial for a more complete evaluation. Parent(s) or guardian(s), please provide the following information.

Child's name: _____ Birthdate: _____

Primary care physician: _____

	Yes	No
1. Did your child have any ear problems* before the age of 1?	_____	_____
2. Has your child ever had a draining ear?	_____	_____
3. Approximately how many ear problems has your child had in his/her life? 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10 or more <input type="checkbox"/>	_____	_____
4. Does your child tend to have 4 or more ear problems each year?	_____	_____
5. Has your child had an ear problem in the last 6 months?	_____	_____
6. Has your child ever had an ear problem that lasted 3 months or longer?	_____	_____
7. Has anyone related to the child had many ear problems?	_____	_____
8. Has your child ever been seen by an ear specialist? If yes, what doctor? _____ Month/year of last visit? _____	_____	_____
9. Has your child ever had tubes placed in his/her eardrum? If yes, how many times? _____ At what age(s)? _____ Which ear? _____	_____	_____
10. Are you concerned about your child's hearing?	_____	_____
11. Please mark all that apply to your child: chicken pox <input type="checkbox"/> head injury <input type="checkbox"/> meningitis <input type="checkbox"/> episode of high fever <input type="checkbox"/> other serious health condition such as cancer <input type="checkbox"/> Please describe the condition: _____ _____		

* Ear problem = ear infection, earaches, draining from ears, medicine taken for ears, fluid behind the eardrum, hole in eardrum, etc.

REFERRAL IS REQUIRED IF A CHILD ANSWERS YES TO ANY ONE INDICATOR ON AN INITIAL HEARING PAPER SCREEN.

Screener: _____ Date: _____

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.

Well Child Check Visual Acuity

Corrected: Yes / No

OD - Right eye: 20/____

OS - Left eye: 20/____

OU - Both eyes: 20/____

Patient is unable to complete visual acuity due to:

***Please remember to document in Cerner intake