Everclear Hearing Products, LLC

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Name______________________________ DOB________ AGE_____ Gender___

School information:____

Grade:_____________ Teacher:______________________________________

<u>Medical Information:</u>

Medications/Supplements: ____

Allergies: ____

Infections at birth: CMV Rubella Herpes Syphilis Toxoplasmosis Jaundice

Was your child in the intensive care unit? N Y

Was your child born premature? N Y

Were there any complications during pregnancy or delivery? N Y ________

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Did your child pass their newborn hearing screening? N Y

Have they had any recent illness? N Y ____________________

____

Family history of hearing loss? N Y

Who: ____

<u>Speech and Hearing History:</u>

Do you think your child has a hearing problem? N Y

Has your child's hearing been tested before? N Y

Does your child startle to loud sounds? N Y

Does your child stop moving/crying when you call them? N Y

Does your child babble/talk? N Y

How many words are in their vocabulary? N Y

Is your child's speech clear to you?	**N**	**Y**
Is it clear to other listeners?	**N**	**Y**
Has your child had pain in their ears recently?	**N**	**Y**
Has your child had any drainage recently?	**N**	**Y**
Fullness or pressure in their ears?	**N**	**Y**
Does your child fall or lose balance easily?	**N**	**Y**

Hearing Aid History

Has your child ever worn hearing aids? **N** **Y**

Make ___________ Model ________ Style_________ Binaural/Monaural

Dispenser____