Pediatric Medical
Health Inventory

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Patient Name: _____ **DOB:** _____
[First] [MI] [Last] [MM / DD / YYYY]

Reason(s) for today's visit:

☐ Failed Newborn Screening :: ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ Missed Newborn Screening ☐ Doctor Referral ☐ Speech Delay

☐ Hospital Newborn Screen Equipment Failure ☐ Other: _____

☐ Parent / Guardian concern :: _____

Hearing Loss Symptoms:

☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ Constant ☐ Fluctuating :: Describe: _____

☐ Gradual ☐ Sudden :: Date of onset: _____

Communication Problems:

☐ Quiet	☐ Noise	☐ Face-to-face	☐ In groups
☐ In classroom	☐ Auditoriums	☐ Close proximity	☐ Direction of sound
☐ In car	☐ Church	☐ At a distance	☐ Television
☐ Listening to music	☐ Theater	☐ Outside	☐ Radio

Other: _____

Related Complaints and History:

Tinnitus / Ringing ::	☐ Both Ears	☐ Right Ear	☐ Left Ear
☐ Dizziness	☐ Balance /Unsteady	☐ Headaches	☐ Nausea
☐ Ear pain	☐ Ear drainage	☐ Ear fullness	
☐ Noise exposure	☐ Speech problems	☐ Language problems	
☐ Attention / concentration difficulties		☐ Play / Interaction with other children	

☐ Special education services received :: _____

Has seen an Ear, Nose and Throat physician? ☐ Yes ☐ No

If yes, physician name :: _____ Approx. when? _____

Other ::

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Family History:

☐ Parents related before marriage ☐ Family history of kidney disease

☐ Family history of thyroid problems ☐ Family history of progressive blindness

☐ Family history of stillbirths / miscarriages

☐ Family history of hearing loss ::

Who?	Age lost?

☐ Siblings with hearing loss ::

Who?	Age lost?

☐ Mother worked outside home during pregnancy? Type of work? _____

☐ Father worked outside home during pregnancy? Type of work? _____

Other (please specify) :: _____

Hearing Aid Use:

☐ No experience ☐ Currently wearing devices :: Approximate length of use: _____

☐ Trial use only ☐ Satisfied with devices

☐ Past experience ☐ Devices not adequate ::

Maternal Pregnancy Questionnaire:

☐ Drugs taken (including antibiotics) :: _____

☐ Exposure to chemicals :: _____

☐ Exposure to radiation :: _____

☐ Illnesses :: _____

☐ Amniocentesis performed ☐ Toxemia ☐ Diabetes

Exposure to: ☐ Chicken Pox ☐ Mumps ☐ Measles ☐ German Measles

Diagnosed with: ☐ Syphilis ☐ Herpes ☐ Influenza ☐ HIV / AIDS

Other concerns during pregnancy :: _____

_____

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Newborn Factors:

☐ Not Full Term: Weeks early? _____ ☐ Birth weight less than 5 pounds: _____ lbs

☐ Hospital of birth :: _____

☐ Induced Labor ☐ Labor less than 3 hours ☐ Labor longer than 24 hours

☐ Forceps delivery ☐ Premature membrane rupture ☐ Cesarean section (C-section)

☐ APGAR score low _____ ☐ Placed in intensive care. How long? _____

☐ Breathing problems at birth ☐ Oxygen given at birth. How long? _____

☐ Defects of ear, nose, throat :: _____

☐ Congenital heart disease ☐ Paralysis at birth ☐ Seizures at birth ☐ Septicemia

☐ Other: _____

Infant / Childhood Factors:

☐ Balance / Gait / Dizziness ☐ Seizures ☐ Cerebral palsy ☐ Head / Skull Injury

☐ Asthma ☐ Allergies ☐ Meningitis ☐ Chicken Pox ☐ Measles ☐ Mumps

☐ Hospitalization ☐ Kidney problems ☐ Vision Problems _____

☐ Ear surgery. When? _____ Type: _____

		Frequency	How many?	Ages
☐ Ear infections	☐ Both ☐ Right ☐ Left			
☐ Tubes	☐ Both ☐ Right ☐ Left			

School Grade:: _____ School Name:: _____

☐ Other :: _____

Medications:

Check following medications you have taken in the past 2 years, or are currently taking:

☐ Streptomycin ☐ Neomycin ☐ Kanamycin ☐ Quinine

☐ Chemotherapy ☐ Aspirin ☐ Anti-inflammatory ☐ Diuretics

List current medications (provide separate list if needed): _____

_____

To the best of my knowledge, the above information is accurate.

Parent/ Guardian Signature _____ Date _____