



WEST COAST HEARING & BALANCE

PEDIATRIC EVALUATION & MANAGEMENT RELEVANT HISTORY

PATIENT NAME (last) _____ (first) _____

DATE OF BIRTH: _____ CHART # _____ DATE: _____

Audiologist: ___ Dr. Frazer ___ Dr. Bennett ___ Ms. Kwast ___ Dr Darchangelo ___ Dr. Nelson ___ Ms Cline ___ Dr Davis ___ Dr Richardson ___ Dr Lam

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 unresponsive 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 or delivery?			
Did the child have an abnormal status at birth?			
Was the child's birth weight less than 3 lbs and 5 oz?			
Has the child had any childhood illnesses or traumas?			
Did the child fail a hearing screening test?			

For Office Use Only

SUMMARY DETAILS:

Discussed test results & speech audiogram w/ patient?

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

RECOMMENDATIONS: ___ Medical &/or ENT follow up ___ Hearing Aid Evaluation ___ ABR ___ VNG

OTHER RX: