Center for Deaf and Hard of Hearing Children
Audiology Services · Indiana State Department of Health
1200 East 42nd Street · Indianapolis, IN 46205-2099
Phone: 317.550.4859 · Fax: 317.550.4873 · ahull@isdh.in.gov

Child's Name: _____
Parent(s)/Legal Guardian Name(s): _____
Address: _____
Phone/Text/VP:_____
Email: _____
Family Language: Spoken English_____ ASL_____ Spanish____ Other: _____
Date of Birth: _____
Hospital Born: _____ Location:_____
Passed the Infant Hearing Screening : YES / NO / NOT SURE
Child's Pediatrician: _____
Child's Ear Nose Throat (ENT) doctor: _____
Maternal Health during Pregnancy (
Complications during Pregnancy (if yes, describe):
_____
_____
_____
Complications during Birth (if yes, describe):
_____
_____
_____
Stay in Neonatal Intensive Care Unit (how long and for what reason):
_____
Family History of Permanent Childhood Hearing Issues (if yes, describe):
_____
_____
_____
Child's History of Health Issues (if yes, describe):
_____
_____
_____
Has the child had a history of fluid or ear infections in the ears? YES / NO/ NOT SURE
If YES, how many? How long do they last? How have they been treated (antibiotics, PE tubes, allergy medicines,
etc.)?_____
_____
Has the child had hearing evaluations in the past? If so, when and where were those evaluations?
_____
_____
Other Information you would like to provide (description of how you think the child hears, how well other people understand the child's speech, etc.):
_____
_____
_____
_____
_____