Revised 04.2016

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 ☐ 3-5 ☐ 6-10 ☐ 10 or more ☐		
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 ☐ head injury ☐ meningitis ☐ episode of high fever ☐

other serious health condition such as cancer ☐

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.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

KBH - EPSDT Blood Lead Screening Questionnaire

To be completed at each KBH screen from 6 to 72 months

Does your child: (circle response received)	**DATE**: (MM/DD/YYYY)						
1) **Live in or visit a house or apartment built before 1960?** This could include a day care center, preschool, or the home of a babysitter or relative.		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
2) **Live in or regularly visit a house or apartment built before 1960 with previous, ongoing, or planned renovation or remodeling?**		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
3) **Have a family member with an elevated blood lead level?**		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
4) **Interact with an adult whose job or hobby involves exposure to lead?** Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
5) **Live near a lead smelter, battery plant, or other lead industry?** Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work)		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
One positive response to the above questions <u>requires</u> a blood lead level test. Remember blood lead levels tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?		**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Interviewing staff initials							

Staff signature

Patient name: _____ **ID number:** _____

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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