

HEARING DEVELOPMENT SCREENING CHECKLIST

Child's Name : _____ Date of birth: _____

Person completing this form: _____ Date: _____

Birth to 3 Months:	YES	NO
Does your child startle, awaken or cry at loud sounds?		
Does your child turn to you when you speak?		
Does your child smile when spoken to?		
Does your child seem to recognize your voice and quiet down if crying?		

4 to 6 Months:	YES	NO
Does your child respond to "No", or changes in your tone of voice?		
Does your child look around for the source of new sounds, e.g., the door bell, vacuum, dog barking?		
Does your child notice toys that make sounds?		

7 Months to 1 Year:	YES	NO
Does your child recognize words for items like "cup", "shoe", "juice"?		
Does your child respond to requests like "Come here" or "Want more"?		
Does your child enjoy games like peek-a-boo or pat-a-cake?		
Does your child turn or look up when you call his or her name?		

1-2 Years:	YES	NO
Can your child point to pictures in a book when they are named?		
Does your child point to a few body parts when asked?		
Can your child follow simple commands and understand simple questions such as: "Roll the ball."... "Kiss the baby."... "Where's your shoe?"		

2-3 Years	YES	NO
Does your child continue to notice sounds (telephone ringing, television sounds or knocking at the door)?		
Can your child follow two requests like: "Get the ball." Or "Put it on the table."		

All Ages:	YES	NO
Do you have any concerns about your child's hearing?		

Conditions associated with possible hearing loss: (Parent or physician may check any that apply)

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|--|---|
| <input type="checkbox"/> repeated episodes of otitis media (ear infection) | <input type="checkbox"/> family history of hearing loss |
| <input type="checkbox"/> prematurity | <input type="checkbox"/> failed hearing screening |
| <input type="checkbox"/> cranio-facial anomalies | <input type="checkbox"/> experienced head trauma |
| <input type="checkbox"/> excessive noise exposure | <input type="checkbox"/> experienced head trauma |
| <input type="checkbox"/> any serious illness (including high fever) | |

Outcome:

Referral to: Audiology evaluation Date: _____
 ENT Assessment Date: _____
 Early On[®] Date: _____