Today's Date: _____

Child's Name: _____

DOB: _____

Hearing Development Screening Checklist

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:

___	___	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 to1 Year:

___	___	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 to 2 Years:

___	___	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 to 3 Years:

___	___	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:

___	___	Do you have any concerns about your child's hearing?

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

___ repeated episodes of otitis media (ear infection)
___ prematurity
___ cranio-facial anomalies
___ excessive noise exposure
___ any serious illness (including high fever)
___ family history of hearing loss
___ failed hearing screening
___ experienced head trauma
___ exposure to ototoxic drugs

Outcome: Referral to: ___Audiology evaluation Date: __-__-__
___ENT assessment Date: __-__-__
___*Early On®* Date: __-__-__

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