

PEDIATRIC AUDIOLOGY HISTORY FORM

Child's Name: _____ DOB: _____

Mother's Name: _____ Father's Name: _____ TODAY'S DATE: _____

How did you hear of us? _____

1. Were there any problems during the child's pregnancy? Yes No
 If yes, please explain: _____

2. Were there any problems during or immediately after child's birth? Yes No
 If yes, please explain: _____

3. Did your child pass a newborn hearing screening? Yes No
 If no, please explain: _____

4. Does your child have a speech and language delay? Yes No
 If yes, please explain: _____

5. Is your child receiving speech language therapy? Yes No
 If yes, please explain: _____

6. Are there any other developmental delays you are concerned about?(behavioral, motoric, etc.) Yes No
 If yes, please explain: _____

7. Does your child have a history of recurrent ear infections? Yes No
 If yes, when was the last infection? _____

8. Has your child had any serious illness such as meningitis, mumps, scarlet fever, very high fever? Yes No
 If yes, please give details: _____

9. Was your child ever hospitalized for an illness? Yes No
 If yes, please give details including medications administered: _____

10. Is there a history of hearing loss in the family? Yes No
 If yes, please give details: _____

11. Has your child ever had a head injury causing a concussion or loss of consciousness? Yes No
 If yes, please give details: _____

12. Has your child ever been exposed to loud noise or music such as: Yes No
 iPods, mp3 players, bands, concerts, firearms, snowmobiles, dirt bikes, power tools, car races?

13. Does your child appear to hear the phone ringing or the doorbell? Yes No

14. Does your child startle to loud sounds? Yes No

15. Does your child listen to the TV or radio at a loud volume setting? Yes No

16. Does your child normally speak loudly? Yes No

17. Does your child react to loud sounds by crying or covering his/her ears? Yes No

18. Does your child respond when you call him/her from another room? Yes No

19. Is your child currently taking any medications? Yes No

If yes, please list: _____

20. Has your child recently seen or is scheduled to see an Ear, Nose and Throat doctor? Yes No

If yes, who and when? _____

21. What are your concerns about your child's hearing? _____