PEDIATRIC HEALTH HISTORY

To be completed by parent or legal guardian

Please complete front and back

Date: _____

Child's Name: _____ Birthdate: _____

Please describe your concerns about your child's hearing (and/or purpose for today's appointment):

_____

_____

Hearing History:

	Y	N
1) Does anyone in the child's family have history of hearing loss *before the age of 30* (immediate and extended family)? If **Yes**, please explain: _____	☐	☐
2) Does the child consistently respond to parent's or caregiver's voice?	☐	☐
3) Does the child respond to sounds from other rooms?	☐	☐
4) When sound is present, or someone is speaking, does the child search for where is it coming from?	☐	☐
5) Has the child's hearing been tested?	☐	☐

If **Yes,** please list the results below:

Newborn screening? _____

At school? _____

*Other location(s)*_____

6) Does your child receive audiology or other hearing services through the school system (including preferential classroom seating)?	☐	☐

If **Yes**, please describe: _____

7) Please describe the child's hearing aid history (Please write N/A if the child has not worn hearing aids)

_____

_____

Pregnancy, Birth and Developmental History:

1) Was the pregnancy/delivery abnormal in any way?
2) Was delivery premature?
3) Did the mother have any illness or take any medications during the pregnancy?
4) After birth, did the child have:

	Y	N
Breathing difficulties?	☐	☐
Any head, neck or ear abnormalities?	☐	☐
Feeding Problems?	☐	☐
Surgery?	☐	☐
Infections requiring medications?	☐	☐

If any **"Yes"** answers above, please describe: _____

5) Does the child lose balance, fall easily, or appear uncoordinated or clumsy? Yes ☐ No ☐

6) Please describe any concerns regarding the child's physical development (or write N/A if no concerns)_____

Medical History:

Please check if the child has had any of the following:

- ☐ Ear Infections
- ☐ Ear Surgery
- ☐ Hospitalization
- ☐ Head trauma/Injury
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Seizures
- ☐ Kidney problems
- ☐ Vision problems
- ☐ Allergies
- ☐ Asthma
- ☐ Noise exposure *(e.g. farm equipment, loud music, hunting)*

Please list any prescription of over-the-counter medications the child is taking *(please include the reason for taking each)*:

_____

_____

_____

_____

Additional History:

1) Do you have any concerns about the child's speech and language? If **Yes**, please explain:_____

_____

2) If the child is 2 or younger, how many words does he/she use? _____

3) Is the child understood by: ____Parents/caregivers ____Siblings _____Other adults

4) Has the child's speech been evaluated? Yes ☐ No ☐

5) Do any parents or caregivers smoke? Yes ☐ No ☐

6) Does the child:

	Y	N
Play/interact well with other children?	☐	☐
Have any difficulty at school?	☐	☐
Receive any special education services?	☐	☐
Have attention/concentration difficulties? *(diagnosed or suspected?)*	☐	☐

If **Yes** to any of the above, please explain: _____

7) Does your child have any condition that should not be brought up in the presence of the child?

_____

_____ _____ _____

Signature of person completing the form Relationship Date