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

	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: ____

____ _________________________ _________________

Signature of person completing the form Relationship to the child Date

____

Printed Name