CHILD HISTORY

LAST NAME :__________________________ FIRST NAME:__________________________ MI:________

Referring Physician: __________________________ Clinic Name: __________________________

Do you think your child has hearing difficulty? Yes ____ No ____ Sometimes ____ If yes, which ear(s)? ________________

When did you notice this problem? ____

Did they pass their newborn screening? Yes ____ No ____ Not Sure ____

Are there concerns about their speech / language? Yes ____ No ____ If yes, please specify: ____________________

Medical History: *(please check or list any injuries for which the child has ever received treatment)*

☐ Anoxia / Hypoxia	☐ Diabetes	☐ Head or Face abnormality	☐ Rubella
☐ Allergies / Sinus problems	☐ Genetic Disorder	☐ High Fever	☐ Scarlet Fever
☐ Anemia	☐ Head Injury	☐ Measles / Mumps	☐ Seizure Disorder
☐ Cancer	☐ Headaches / Migraine	☐ Cleft Palate or Lip	☐ Stroke
☐ Cerebral Palsy	☐ Heart Abnormality	☐ Chicken Pox	☐ Hepatitis (A,B, or C)

Other: ____

Do they have any of the following:

Frequent colds or illness?	☐ Yes ☐ No	When was the most recent? ____________________
Frequent ear infections?	☐ Yes ☐ No	When was the most recent? ____________________
Discharge or drainage from ears?	☐ Yes ☐ No	Please describe: ____________________
Allergies or sinus problems	☐ Yes ☐ No	Please describe: ____________________
History of ear surgery (including tubes)?	☐ Yes ☐ No	Please describe: ____________________
Family history of hearing loss?	☐ Yes ☐ No	Please describe: ____________________
Family history of speech delay?	☐ Yes ☐ No	Please describe: ____________________
Poor balance or walking ability	☐ Yes ☐ No	Please describe: ____________________

Medications: ____

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Hearing History:

Startles or wakes up to loud sounds?	☐ Yes ☐ No	Please describe: ____________________
Tries to locate the source of a sound?	☐ Yes ☐ No	Please describe: ____________________
Presently wears/uses a hearing instrument?	☐ Yes ☐ No	Please describe: ____________________

Developmental History:

Have their developmental milestones been age appropriate?	☐ Yes	☐ No	☐ Not Sure
Have they been diagnosed with an expressive / receptive speech delay?	☐ Yes	☐ No	☐ Not Sure
Are there multiple languages in the home?	☐ Yes	☐ No	☐ Not Sure
Have they been diagnosed with autism / pervasive developmental disorder (PDD)?	☐ Yes	☐ No	☐ Not Sure
Have they been diagnosed with Down Syndrome?	☐ Yes	☐ No	☐ Not Sure
Have they been diagnosed with ADD / ADHD?	☐ Yes	☐ No	☐ Not Sure
Are they currently being evaluated for any developmental or social problems?	☐ Yes	☐ No	☐ Not Sure
Are they receiving any therapy (speech, physical therapy or developmental)?	☐ Yes	☐ No	☐ Not Sure

NOTES *(Internal Use Only)*:____

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