AUDIOLOGY CHILD HISTORY FORM

Child's legal name: ____ Date of birth: ________________________

Guardian's legal name: __________________________________ Referring doctor: ___________________________

Reason for referral: ____

When was this problem first noted? ____

Dates of previous hearing tests: ____________________________ Results: _________________________________

Family history: Childhood deafness in family? Yes No Relationship: ___________________________________

Prenatal history: Exposure to viral diseases during pregnancy? Yes No

If yes, explain: _____________________________________ At what month of pregnancy? ____________________

Alcohol or recreational drug use during pregnancy? ____

Any complications during pregnancy? ____

Birth history: Gestational age at birth: __________________ Birth weight: _________________________

Please circle if any of the following were present at or after birth: Sepsis/infection Hyperbilirubinemia

Asphyxia CMV Craniofacial abnormalities Chromosomal abnormalities/syndromes Other

If other, please explain: ____

Developmental history: At what age did your child begin babbling? _____________

Respond to name? __________ Say first words? ____________ Use 2-3 word phrases? _____________

Other comments about speech/language development: ____

Medical history: History of ear infections: Yes No If yes, how many? ____________ How often? ___________

Medications used for treatment? ____

Has surgery been performed on the ears? Yes No If yes, when/where? ___________________________________

If your child has had any of the following, please briefly explain history and treatment:

__Cleft lip and/or palate: ____

__Seizures: ____

__Allergies: ____

__Meningitis: ____

__Frequent colds/high fevers: ____

__Kidney disease: ____

__Vision loss: ____

__Other: ____

Current medications: ____

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