COMPREHENSIVE
AUDIOLOGY
ESTHER FOGEL, AuD

Audiology History – Child

Patient's Name_____ Date of Birth_____ __M __F

Today's Date_____ Form Completed By_____

Name of Pediatrician_____ Phone Number_____

Address of Pediatrician_____

Emergency Contact _____Phone #_____ Relationship_____

Referred by_____ Reason_____

HEARING

What is your primary reason for today's visit? _____

Do you suspect that your child has a hearing problem? ____ Yes ____No
If yes, for how long? _____

Is there a family history of hearing loss? ___Yes ___No If yes, please specify _____

Please check any of the following that apply to your child:

___Concern by a family member or teacher that your child is not quick to hear things
___Delays in the development of your child's ability to speak and use language as compared to others of the same age
___Difficulty paying attention and behaving
___Difficulty with academic performance
___Inappropriate, delayed, or lack of response to soft and moderate-level sounds or spoken language when distractions are minimal
___Frequent use of "what?" or "huh?"
___Intently watching the faces of speakers
___Difficulty understanding speech when there is background noise
___Sitting close to the TV when the volume is loud enough for others; increasing the volume on the TV or other audio electronics to unreasonably loud levels
___Not responding to voices over the telephone or continually switching ears when on the phone
___Not "jumping" or becoming startled by sudden, loud noises
___Unable to accurately figure out where a sound is coming from

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Please list any specialists (audiologists. ENT, etc.) that you have consulted with regarding your child's hearing or speech/language concerns:
Name of Specialist_____ Date_____
Name of Specialist _____ Date_____

BIRTH HISTORY

Hospital of Birth_____ Birth Weight_____

Gestational age at birth: _____full term ____premature

Nursery: ____Well-baby _____NICU

Please list any prenatal complications_____

Please list any delivery complications _____

Did your child pass the newborn hearing screening? ___Yes ___No

MEDICAL HISTORY

Does your child have a history of any of the following? Please check all that apply:
____Ear infections
____Ear, Nose, or Throat surgery Please describe_____
____Ear Pain or Discomfort
____Ear Drainage
____Ear Fullness / Pressure
____Enlarged tonsils or adenoids
____Excessive cerumen (ear wax)
____Sensitivity to loud sounds

Does your child have a history of any of the following medical conditions? Please check all that apply:
____Heart condition
____Kidney condition or hydronephrosis
____Vision loss
____CMV
____Allergies / Asthma / Hay Fever
____Measles or Mumps
____Meningitis
____Other _____

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Please list any **medications** that your child is taking currently:

Medication _____ Reason_____

Medication _____ Reason_____

Medication _____ Reason_____

Please list any **allergies** to medications or foods_____

Is your child allergic to latex gloves? __Yes __No

Please list any previous **surgeries** or **hospitalizations**? _____

_____

DEVELOPMENTAL MILESTONES

Does your child understand / follow simple commands? ____Yes ____No

Is your child's speech difficult to understand? ____Yes ____No

Is your child using ____Single words ____Phrases ____ Sentences

Physical / Motor Development: ____Age appropriate ____Delayed

Speech / Language Development: ____Age appropriate ____Delayed

EDUCATIONAL HISTORY

What school / daycare does your child attend? _____
Grade_____

Does your child receive any educational support services? ____Yes ____No

Please check all that apply:
_____Speech therapy
_____Occupational therapy
_____Physical therapy
_____Special education teacher
_____ABA
_____Counselling

For children age 0-3: Is your child enrolled in the Early Intervention Program? ____Yes ____No

If yes, what services is your child receiving? _____

OTHER

Is there anything else you would like to tell us about your child?

_____

_____