

# AUDIOLOGY ASSOCIATES

*hear today, hear tomorrow*

## PEDIATRIC HISTORY

### HEARING AND SPEECH HISTORY

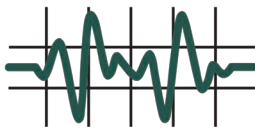
YES NO

Do you think your child has a hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>
When did you consult a physician about your child's ears? _____		
If yes, how old was your child when you first noticed? _____		
Has your child's hearing been tested before?	<input type="checkbox"/>	<input type="checkbox"/>
Does your newborn startle at loud sounds?	<input type="checkbox"/>	<input type="checkbox"/>
Does your 3 month old stop moving or crying when you call them?	<input type="checkbox"/>	<input type="checkbox"/>
Does your 6 month old enjoy noise making toys?	<input type="checkbox"/>	<input type="checkbox"/>
Does your 9 month old babble frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Does your 1 year old respond to simple commands?	<input type="checkbox"/>	<input type="checkbox"/>
At what age did your child first babble?		
As what age did your child say their first word?		
At what age did your child start speaking short (2-3 word) sentences?		
How many words does your child have in their vocabulary?		
How often does your child use speech?		
<input type="checkbox"/> Frequently <input type="checkbox"/> Occasionally <input type="checkbox"/> Seldom <input type="checkbox"/> Never <input type="checkbox"/> N/A		
Is your child's speech clear?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
How did you hear about our services?		
<input type="checkbox"/> MD Referral <input type="checkbox"/> Advertisement <input type="checkbox"/> School		
<input type="checkbox"/> Friend <input type="checkbox"/> Previous Patient <input type="checkbox"/> Social Media		
Did your child have any of the following infections at birth?		
<input type="checkbox"/> None <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Rubella		
<input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> Toxoplasmosis		

### MEDICAL HISTORY

YES NO

Did your child have asphyxia or breathing problems at birth?	<input type="checkbox"/>	<input type="checkbox"/>
Were any blood transfusions given?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe: _____		
Was your child in an intensive care unit?	<input type="checkbox"/>	<input type="checkbox"/>
Any congenital malformations involving the head, neck, or ears?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born prematurely?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many weeks? _____		
What was your child's birth weight? _____		
Was your child treated with any antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what kind: _____		
Did your child ever have meningitis?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what age? _____		
Did your child ever have elevated bilirubin (jaundice)?	<input type="checkbox"/>	<input type="checkbox"/>



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## QUESTIONS CONTINUED....

YES

NO

Did your child pass a newborn hearing screening?  YES  NO

Is there a family history of hearing problems in early childhood?  YES  NO

Mother  Sister  Father  Brother  Uncle

Grandmother  Grandfather  Aunt  Cousin  Other

Does your child have any of the following associated disability?  YES  NO

Blindness or vision disorder  Cerebral Palsy

Developmental disability  Seizure  Down Syndrome

Learning disability  Other: \_\_\_\_\_

Any recent illnesses?  YES  NO

If yes, what? \_\_\_\_\_

Has your child had any earaches?  YES  NO

If yes, which ear(s)?  LEFT  RIGHT  BOTH

Have their ears been medically treated?  YES  NO

If yes, which ear(s)?  LEFT  RIGHT  BOTH

Is your child receiving any medication?  YES  NO

If yes, what kind? \_\_\_\_\_

Has your child experienced dizziness?  YES  NO

Has your child had a history of high fever?  YES  NO

## PATIENT/GUARDIAN CONSENT

I, \_\_\_\_\_ the undersigning parent/guardian having legal custody/guardianship of \_\_\_\_\_ a minor, do hereby authorize, request, and direct Audiology Associates to perform in judgement any examination and audiologic diagnosis or treatment which is deemed necessary.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature