AUDIOLOGY ASSOCIATES

hear today, hear tomorrow

PEDIATRIC HISTORY

HEARING AND SPEECH HISTORY	YES	NO
Do you think your child has a hearing problem?	☐	☐
When did you consult a physician about your child's ears?_____		
If yes, how old was your child when your first noticed?_____		
Has your child's hearing been tested before?	☐	☐
Does your newborn startle at loud sounds?	☐	☐
Does your 3 month old stop moving or crying when you call them?	☐	☐
Does your 6 month old enjoy noise making toys?	☐	☐
Does your 9 month old babble frequently?	☐	☐
Does your 1 year old respond to simple commands?	☐	☐

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?

☐Frequently ☐Occasionally ☐Seldom ☐Never ☐N/A

Is your child's speech clear? ☐YES ☐NO ☐N/A

How did you hear about our services?

☐MD Referral ☐Advertisement ☐School
☐Friend ☐Previous Patient ☐Social Media

Did your child have any of the following infections at birth?

☐None ☐Cytomegalovirus ☐Rubella
☐Herpes ☐Syphillis ☐Toxoplasmosis

MEDICAL HISTORY	YES	NO
Did your child have asphyxia or breathing problems at birth?	☐	☐
Were any blood transfusions given?	☐	☐
If yes, please describe:_____		
Was your child in an intensive care unit?	☐	☐
Any congenital malformations involving the head, neck, or ears?	☐	☐
Was your child born prematurely?	☐	☐
If yes, how many weeks?_____		
What was your child's birth weight?_____		
Was your child treated with any antibiotics?	☐	☐
If yes, what kind:_____		
Did your child ever have meningitis?	☐	☐
If yes, what age?_____		
Did your child ever have elevated bilirubin (jaundice)?	☐	☐

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QUESTIONS CONTINUED….	YES	NO
Did your child pass a newborn hearing screening?	☐	☐
Is there a family history of hearing problems in early childhood?	☐	☐
☐Mother ☐Sister ☐Father ☐Brother ☐Uncle ☐Grandmother ☐Grandfather ☐Aunt ☐Cousin ☐Other		
Does your child have any of the following associated disability?	☐	☐
☐Blindness or vision disorder ☐Cerebral Palsy ☐Developmental disability ☐Seizure ☐Down Syndrome ☐Learning disability ☐Other:_____		
Any recent illnesses?	☐	☐
If yes, what?_____		
Has your child had any earaches?	☐	☐
If yes, which ear(s)? ☐LEFT ☐RIGHT ☐BOTH		
Have their ears been medically treated?	☐	☐
If yes, which ear(s)? ☐LEFT ☐RIGHT ☐BOTH		
Is your child receiving any medication?	☐	☐
If yes, what kind?_____		
Has your child experienced dizziness?	☐	☒
Has your child had a history of high fever?	☐	☐

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