

# Pediatric Audiology History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Pediatrician: \_\_\_\_\_  
Please send a report to my pediatrician \_\_\_\_\_ Yes \_\_\_\_\_ No  
Sex and Ages of Siblings: \_\_\_\_\_

Please check and/or describe all that apply below including the age at which occurred.

## Pre-Natal (Pregnancy)

Length/Term \_\_\_\_\_  
Illness \_\_\_\_\_  
Medications \_\_\_\_\_  
RH Factor \_\_\_\_\_  
TORCH Infection \_\_\_\_\_  
(toxoplasmosis, rubella ,  
Cytomegalovirus ,herpes)

## Delivery

Duration/Labor \_\_\_\_\_  
C-Section \_\_\_\_\_  
Position \_\_\_\_\_  
Anesthesia \_\_\_\_\_  
Complications \_\_\_\_\_  
APGAR 0-4 1minute  
APGAR 0-6 5minutes

## Post- Partum

Birth Weight \_\_\_\_\_  
Received Blood \_\_\_\_\_  
Medications \_\_\_\_\_  
Cleft Palate \_\_\_\_\_  
Lack of Oxygen \_\_\_\_\_  
Jaundice \_\_\_\_\_  
Craniofacial Anomalies \_\_\_\_\_  
Incubator \_\_\_\_\_

## Infancy and Childhood

At what age did your child walk? \_\_\_\_\_  
At what age did your child say his first word? \_\_\_\_\_

## Medical History

High Fevers/Serious Illnesses \_\_\_\_\_  
Seizures/Convulsions \_\_\_\_\_  
Hospitalizations/Surgeries including tonsillectomy, adenoidectomy and/or myringotomy with or without insertion of tympanostomy tubes \_\_\_\_\_  
Past/Present Medications \_\_\_\_\_  
Family history of hearing loss \_\_\_\_\_

## Social History

Does your child interact well with others his/her own age? \_\_\_\_\_  
Behavior Problems? \_\_\_\_\_  
School Grade \_\_\_\_\_ School Progress \_\_\_\_\_  
School your child is presently attending \_\_\_\_\_  
Name of your child's teacher \_\_\_\_\_  
(Please send a report to my child's school \_\_\_\_\_ Yes \_\_\_\_\_ No)