Nanci Campbell AuD
Doctor of Audiology

Pediatric History Form

Patient Name_____ Birth Date _____ Age _____
Person Completing Form_____ Relationship to patient _____

Primary Concerns: (Please check Yes or No)
Do you feel this child has a hearing loss? ☐ Yes ☐ No
Are you concerned about this child's speech or language development? ☐ Yes ☐ No
Please describe concern: _____
_____

Pregnancy or Birth complications, please list if applicable _____
_____

Please describe any family history of hearing loss before age 40 _____
_____

Communication and Developmental History: (Please check Yes or No)

Difficulty with pronunciation?	☐ Yes	☐ No
Language development concerns?	☐ Yes	☐ No
Difficulty listening or understanding conversation?	☐ Yes	☐ No
Attention problems at school?	☐ Yes	☐ No
Other developmental delays?	☐ Yes	☐ No

Hearing and Middle Ear History: (Please check Yes or No)

Previous hearing testing?	☐ Yes	☐ No
Balance or coordination difficulties? Please describe? _____		
Tinnitus or noises in ears?	☐ Yes	☐ No
Exposure to hazardous noises?	☐ Yes	☐ No
Allergies?	☐ Yes	☐ No

Middle Ear Health:
Number of ear infections_____ Have they resolved?_____ At what age?_____
P.E. tubes placed? _____ When?_____ By what Doctor?_____

History of ear pain?	☐ Yes	☐ No

General Observations:

Does child respond to voices or environmental sounds?	☐ Yes	☐ No
Does the child startle to loud noises?	☐ Yes	☐ No
Does the child find the source of the sounds?	☐ Yes	☐ No

Physical and General Health Conditions: Please List _____
_____

Current Medications and/or Supplements: Please List
_____
_____

Acknowledgement

I acknowledge by my signature below that I have been given the opportunity to review the Updated Notice of Privacy Practices for the office of Dr. Nanci Campbell. I have been informed that my personal information will **not** be shared with anyone without my permission.

Guardian Signature _____

Relationship _____

Date signed _____