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PEDIATRIC HISTORY FORM

NAME: _____ AGE: _____

1. Why is your child having a hearing test today ?
   _____
   _____
   _____

2. Has your child ever had a hearing test before ? Yes No
   If yes, when ? _____

3. Does your child have a history of middle ear infections ? Yes No
   Date of the most recent infection _____

4. How does your child communicate his or her wishes ?
   _____
   _____

5. How many words does he or she use ? _____

6. Does your child localize to sounds such as the phone or door bell ? Yes No

7. Is there a history of hearing loss in the family ? Yes No
   If yes, who _____

8. Birth History:

Was the pregnancy full term ?	Yes	No
Were there complications at birth ?	Yes	No

Birth weight _____

9. Developmental History:

When did your child crawl? _____

When did your child walk ? _____

When did your child say his or her first meaningful word ?

_____

10. Medical History: (Please circle)

High Fevers	Mumps	Measles	Rubella
Allergies	Tonsillitis	Asthma	Diabetes

11. Is your child presently taking medication ? Yes No

Please list: _____

_____

_____

Please feel free to include any additional comments that you feel may assist us when testing your child.

_____

_____

_____