

# Audiology Partners, LLC

## Pediatric History Form

Date: \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Relationship to child \_\_\_\_\_

### **Identification**

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_ Grade \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

### **Prenatal and Birth History**

#### **Pregnancy**

Unusual illnesses or conditions during pregnancy \_\_\_\_\_

Length of pregnancy \_\_\_\_\_

Duration of Labor up to birth \_\_\_\_\_

#### **Birth**

Birth weight \_\_\_\_\_

Type of delivery (breech, c-section, normal, etc.) \_\_\_\_\_

Any complications? \_\_\_\_\_

Was child blue or jaundiced? \_\_\_\_\_

### **Family History**

Are there any other children in the home? \_\_\_\_\_ Ages \_\_\_\_\_

Do they have any hearing or speech problems? \_\_\_\_\_

Any hearing problems among parents or relatives \_\_\_\_\_

(If yes, please explain.) \_\_\_\_\_

Is there any family history of ear problems and/or surgery? \_\_\_\_\_

**History of Illness and Physical Development:**

**Illnesses**

Has your child been in generally good health? \_\_\_\_\_

Has your child had any of the following?

- |                     |                     |
|---------------------|---------------------|
| _____ Allergies     | _____ Chronic colds |
| _____ Measles       | _____ Tonsillitis   |
| _____ Scarlet Fever | _____ Pneumonia     |
| _____ Flu           | _____ Convulsions   |
| _____ Head Trauma   | _____ Meningitis    |
| _____ Mumps         | _____ Other         |

Ear infections: Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

Date of most recent infection \_\_\_\_\_

Treatment? \_\_\_\_\_

Tonsils and/or Adenoids removed? \_\_\_\_\_

Has child ever been examined or treated by an ear doctor? \_\_\_\_\_

If so, what treatment was prescribed? \_\_\_\_\_

Any ear surgery performed? \_\_\_\_\_

Does your child take now, or has he/she previously taken any medications?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

Has your child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Auditory Behaviors:**

Does the child startle to sounds? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child respond to sounds? Yes \_\_\_\_\_ No \_\_\_\_\_

Is child annoyed by loud sounds? Yes \_\_\_\_\_ No \_\_\_\_\_

Is child easily distracted by soft sounds  
or slight movements? Yes \_\_\_\_\_ No \_\_\_\_\_

**Language Behavior:**

As a baby, did/does your child use his/her voice for pleasure (coo, babble, sing, laugh)?

Yes \_\_\_\_\_ No \_\_\_\_\_

When did child use his/her first words? \_\_\_\_\_

When did child begin to use two-word phrases?

Did this behavior suddenly stop or decrease significantly in amount? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Does your child:

Use his/her voice to make needs known? Yes \_\_\_\_\_ No \_\_\_\_\_  
Use meaningful gestures (more than just pointing) Yes \_\_\_\_\_ No \_\_\_\_\_  
Use speech that is understandable to others? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has your child ever had a speech language evaluation? Yes \_\_\_\_\_ No \_\_\_\_\_  
Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

At what age did you child

Use single words \_\_\_\_\_  
Combine words and phrases \_\_\_\_\_  
Understand simple commands \_\_\_\_\_

**Educational History:**

Age when child entered school \_\_\_\_\_

School attending? \_\_\_\_\_

Is work satisfactory? Yes \_\_\_\_\_ No \_\_\_\_\_

Is, or was, your child in a special program, or receiving additional help?

Yes \_\_\_\_\_ No \_\_\_\_\_

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

\_\_\_\_\_

*To whom do you want a report sent? Addresses are appreciated.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_