SILVERAUDIOLOGY

AUDIOLOGY PEDIATRIC HISTORY

Name of patient (PRINT) _____ Today's date _____

Name of person filling out the form _____ Relationship _____

What is the reason for your visit today?

_____

Please list all the health conditions your child is being treated for and the medications they are taking:

_____

_____

YES	NO	
☐	☐	Does your child have trouble hearing?
☐	☐	Has anyone suggested your child has difficulty hearing?
☐	☐	Did your child pass the newborn hearing screening?
☐	☐	Were there any complications with your pregnancy or birth?
☐	☐	Was your child born early?
☐	☐	Does anyone related to your child have hearing loss?
☐	☐	Does anyone in the home smoke?
☐	☐	Does your child have allergies?
☐	☐	Has your child been diagnosed with any syndromes?
☐	☐	Has your child had any serious illnesses or injuries?
☐	☐	Has your child had any ear infections?
☐	☐	Has your child ever been seen by an ear specialist (ENT)?

YES	NO	
☐	☐	Does your child have an upcoming appointment with an ENT specialist?
☐	☐	Has your child had ear surgery?
☐	☐	Does your child have pain in their ears?
☐	☐	Has your child had drainage from their ears?
☐	☐	Has your child been treated for an ear infection?
☐	☐	Is your child's speech appropriate for their age?
☐	☐	Is your child meeting gross motor milestones?
☐	☐	Is your child receiving any special services?
☐	☐	Does your child snore?

If you answered "YES" to any of the above questions, please explain:

_____

_____

_____

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