Children's
National Medical Center

AUDIOLOGY HISTORY FORM

Name: _____ Birthday: _____ Date of Appointment: _____

Referred By: _____ School: _____ Grade: _____

Reason for hearing test: _____
_____
_____

HEARING (AUDIOLOGIC) HISTORY	**Please Check (X):**	**NO**	**YES**
1. Any previous hearing tests/screenings? When? _____ Where? _____ Results: _____		( )	( )
2. Evoked Response – Auditory Brainstem hearing testing (ABR, BAER)? When? _____ Where? _____ Results: _____		( )	( )
3. Are there parental or teacher concerns regarding child's hearing?		( )	( )
4. Is there a family history of permanent childhood hearing loss? (not due to ear infections)		( )	( )
5. Does your child have a history of ear infections? How many? _____ Age: _____ How treated? (antibiotics, tubes) _____		( )	( )
6. Has your child ever seen an Ear, Nose, & Throat (ENT) physician?		( )	( )
7. Any history of ear surgery? (tubes, adenoidectomy, repaired perforation, mastoidectomy, etc.) Specify: _____		( )	( )
8. Has your child ever been exposed to loud noises? (gun shot, close firecracker, industrial noise, firing range, noise-related hobbies?)		( )	( )

HEALTH HISTORY

1. Any complications during mother's pregnancy? (rubella, toxoplasmosis, syphilis, CMV-cytomegalovirus, herpes) Specify: _____		( )	( )

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		NO	YES
2.	Name of the hospital where your child was born: _____		
3.	Was the child born prematurely?	( )	( )
	How many weeks premature? _____ Placed in NICU?	( )	( )
4.	Any problems during the newborn period (please check) ___ Jaundice ___ Bacterial meningitis ___ Oxygen required ___ Malformation of the head ___ Low birth weight (cleft palate/lip) (less than 1500g (3.5 lbs) ___ Other (Down Syndrome, etc) specify _____	( )	( )
5.	Has your child ever had any serious illnesses? (please check) ___ Pneumonia ___ Meningitis ___ High fever (104 +) ___ Encephalitis ___ Seizures ___ Mumps ___ Scarlet Fever ___ Chicken pox ___ Cardiac problems ___ Measles (rubella or rubella) ___ other: Specify: _____	( )	( )
6.	Has your child ever been hospitalized? Why? _____ When? _____ Where: _____	( )	( )
7.	Past medications (Chemotherapy or mycins?–streptomycin, gentamycin, kanamycin, etc.)	( )	( )
8.	Any history of head injury (with loss of consciousness)?	( )	( )
9.	Has your child been seen by other departments at Children's Hospital? Specify: _____ _____	( )	( )
10.	Are your child's immunizations up to date?	( )	( )

DEVELOPMENTAL HISTORY

1.	Is there a current or past history of problems with speech and language development?	( )	( )
	- Has your child received a speech/language evaluation?	( )	( )
	- Has your child received speech/language therapy?	( )	( )
	Please specify: where, when, how long: _____ _____		
2.	Any learning or academic problems?	( )	( )
3.	Does your child receive special education services? (reading resource, special-ed. classroom, etc Specify: _____	( )	( )