AUDIOLOGY HISTORY FORM

Name: ____________________________  Birthday: ___________  Date of Appointment: ____________

Referred By: ________________________  School: ____________________  Grade: __________

Reason for hearing test: ____________________________________________________________

________________________________________________________________________________

HEARING (AUDIOLOGIC) HISTORY

1. Any previous hearing tests/screenings?  Please Check ( X ):  NO  YES
   When? ____________ Where? ________________
   Results: ____________________________________________________________

2. Evoked Response – Auditory Brainstem hearing testing (ABR, BAER)?  Please Check ( X ):  NO  YES
   When? ____________ Where? ________________
   Results: ____________________________________________________________

3. Are there parental or teacher concerns regarding child’s hearing?  Please Check ( X ):  NO  YES

4. Is there a family history of permanent childhood hearing loss?  Please Check ( X ):  NO  YES
   (not due to ear infections)

5. Does your child have a history of ear infections?  Please Check ( X ):  NO  YES
   How many? ____________  Age: ________________
   How treated? (antibiotics, tubes) ________________

6. Has your child ever seen an Ear, Nose, & Throat (ENT) physician?  Please Check ( X ):  NO  YES

7. Any history of ear surgery? (tubes, adenoidectomy, repaired perforation, mastoidectomy, etc.)
   Specify: ____________________________________________________________

8. Has your child ever been exposed to loud noises?  Please Check ( X ):  NO  YES
   (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: ____________________________________________________________

-Page 1 of 2-
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  (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? ____________________________  Where: ____________________________
   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: ________________________________________________________________