Pediatric History Form **Date:** _____

Name: _____

1. ___Yes ___No Family history of hearing loss?
2. ___Yes ___No Birth or delivery complications?
   If yes, explain: _____
   _____
3. ___Yes ___No Was child in NICU? If so, how long? _____
4. ___Yes ___No Was the child on a ventilator?
5. ___Yes ___No Has child had significant infections, ear or otherwise?
6. ___Yes ___No History of middle ear problems? Date of last ear infection? _____
7. ___Yes ___No Does child have history of PE tube placement?
8. ___Yes ___No History of pain or drainage from the ears?
9. ___Yes ___No Does child tug at his/her ears?
10. ___Yes ___No Do you suspect hearing loss? If yes, Explain: _____
    _____
11. ___Yes ___No Has the child had a hearing test before? If yes, What were the results? _____
    _____
12. ___Yes ___No Does the child use amplification? If yes, what type? _____
    _____
13. ___Yes ___No Is the child on any medications? Please list: _____
    _____
    _____
14. ___Yes ___No Does child have any Developmental Delays? If yes, explain: _____
    _____
15. ___Yes ___No Speech/Language Delays? If yes, explain: _____
16. ___Good ___Fair ___Poor Rate child's performance in school. Explain: _____
    _____
17. ___Yes ___No Has the child been diagnosed with ADD/ADHD?
18. ___Yes ___No Has child been diagnosed with syndromic illness? If yes, explain: _____
    _____
19. ___Yes ___No Was the child born with any significant birth defects: If yes, explain: _____
    _____
20. ___Yes ___No Did the child have a newborn hearing screening? If yes, explain results: _____
    _____

INFANT

21. ___Yes ___No Does the child startle to loud sounds?
22. ___Yes ___No Does the child recognize voices/respond to sound?
23. ___Yes ___No Does the child look for the source of noises or sounds?