Pediatric Medical History

Patient Name:______________________________DOB:______________Today'sDate______________

Home Address: ____

City:______________________________ State: ____________________ Zip: __________________

Home Phone (_____)______________ Cell (_____) ________________

Person completing this form ____________________________Relationship ____________________

Reason for Referral ____

____

Referred By ____________________________ Pediatrician:______________________________

Background Information

Suspected hearing difficulty? Right ear _______Left ear _______ Both ears _______

Does your child turn the TV loud? Yes ___ No ___ Does your child speak in a loud voice? Yes ___ No ___

Has your child failed any hearing screenings? School? Yes____ No____ Pediatrician? Yes _____ No_____

Does your child have a history of ear infections? Yes_____ No_____ Chronic or Recurrent?

When did the ear infections begin? __________________

Has your child had ear surgery? Yes _____ No _____ When?______________________________

Family history of hearing loss? Yes _____ No _____ If yes, explain:__________________________

____

Has your child had a serious head injury? Yes___No___ Concussion or loss of consciousness? Yes___No___

Has your child been hospitalized for any reason? Yes___ No___ Explain:______________________

____

Please list your child's medications:____

Medical Information: Check all that apply

Ear Pain (otalgia)	_____	Ear drainage (otorrhea)	_____	Aural Fullness	_____
Tinnitus (ringing in ears)	_____	Dizziness/Imbalance	_____	Diabetes	_____
Freq. Headaches	_____	Freq. Nausea	_____	Noise Exposure	_____
Meningitis	_____	Tuberculosis	_____	Scarlet Fever	_____

Developmental History:

Was the pregnancy and delivery within normal limits? _____ Full Term?_____ If no, please explain__________

____

Pre/Postnatal complications? ____

Birth Weight: ________________ Length ______________

At what age did your child: Sit Unsupported __________Crawl__________Walked Independently__________

Speak Single Words____________ Combine Words___________ Were there any articulation problems? Yes No

Childhood illness: Chicken Pox _______ Measles _______ Mumps _______ Elevated Fever _______Convulsions or Seizures _______

Was your child seen by Early Intervention? _______If yes, please explain ______________________

Additional Information:

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