Audiology Child History Form

Child's Name: ____
Last *First* *M.I.*

Birth Date: ______________________________ Age: ______________

Parent/Guardian: ____
Last *First* *M.I.*

Referred by: ____

____

1. **Reason for Referral**____
   When was problem first noted? ____
   Previous hearing test? ______________________Results?______________________

2. **Family History**
   Childhood deafness in family? ____
   Relationship to patient?____

3. **Prenatal History**
   Exposure to viral diseases during pregnancy? ____
   If yes, which virus and at which month?____
   Alcohol or recreational drug use during pregnancy? ____
   Other complications during pregnancy? ____

4. **Birth History**
   Gestational age at birth? ______________________Birth Weight?______________________
   Please check if any of the following were present at or after birth:
   ☐ Sepsis/Infection ☐Hyperbilirubinemia ☐Asphyxia

   ☐Craniofacial Abnormalities ☐CMV ☐Chromosomal Abnormalities/Syndromes

   ☐Other Complications____

5. **Developmental History**
   At what ages did you child: begin babbling? ______________Respond to his/her name?______________
   Say first words? ______________________Use 2-3 word phrases?______________________
   Other comments about speech/language development: ____
   At what age did your child: Sit up alone? ___________Crawl? ______________ Walk?______________
   Other comments about motor development: ____

6. **Medical History**
   History of ear infections? _________If yes, how many?____

   Were medications used for treatment?____

   Was surgery performed on the ears? _________If yes, when?____

   Has your child had any of the following; If yes, please explain:
   ☐ Cleft Lip and/ or Palate____
   ☐Seizures____
   ☐Allergies____
   ☐Meningitis____
   ☐Frequent colds/High Fevers____
   ☐Kidney Disease____
   ☐Vision Loss____
   ☐Other____
   Is your child currently on any medications?____