

CHILDREN'S HISTORY FORM

Child's Name: _____ Age: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

INFORMATION ABOUT PROBLEM:

Reason for this visit: _____

Who first noticed your child's hearing problem and when? _____

Do your child's hearing levels seem to fluctuate? _____

Was the onset sudden or gradual? _____

Has your child been seen by a physician for the hearing loss? _____

What has been done about the hearing loss? _____

What do you feel caused the hearing problem? _____

BIRTH HISTORY:

Were there any unusual problems at birth? _____

Exposure to viral diseases during pregnancy? _____

List any drugs taken during pregnancy? _____

Baby's birth weight: _____ Premature? _____

Were there any health problems during the first two weeks of your child's life:

- | | |
|---|---|
| <input type="checkbox"/> Jaundiced at birth | <input type="checkbox"/> Hemorrhage |
| <input type="checkbox"/> Jaundiced after 2-3 days | <input type="checkbox"/> Intravenous fluids |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Incubator or isolette | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Feeding difficulty |
| <input type="checkbox"/> Transfusions | <input type="checkbox"/> Medications |

Other: (please describe) _____

MEDICAL HISTORY

General current medical condition: poor fair good excellent

Has your child ever been hospitalized? _____

List any operations: _____

List any chronic illnesses: _____

List any medications taken by your child: _____

How is your child's vision?: _____

HEARING HISTORY

Ear infections yes no when?

Tubes placed in ears yes no when?

Dizziness yes no when?

Ringing in ears yes no when?

Pain/discomfort in ears yes no when?

Nausea yes no when?

Head trauma yes no when?

Holes in eardrums yes no when?

Did your child have 3 or more ear infections during the first year of life?

Has your child ever had an ear infection that lasted more than 3 months?

Has your child had an ear infection within the past 3 months prior to this evaluation? _____

Has your child had any of the following?:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chronic colds | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Allergies |

SPEECH AND LANGUAGE HISTORY:

At what age did your child say his/her first words? _____

At what age did he/she first put 2 words together? _____

How does your child communicate now?

- | | |
|---|--|
| <input type="checkbox"/> Sentences | <input type="checkbox"/> single words |
| <input type="checkbox"/> 3-4 word phrases | <input type="checkbox"/> points, sounds, crying and noises |
| <input type="checkbox"/> 1-2 word phrases | |

Has your child's speech and language ever been evaluated, if so, when and where? _____

FAMILY HISTORY:

Do any of your child's relatives have hearing or speech problems? Who and at what age was it identified? _____

HEARING AID HISTORY

Has your child ever worn a hearing aid? ____ if yes, please answer the following:

Does your child wear one now? ____ Make and Model _____

When did he/she start wearing a hearing aid? _____

When did you purchase the present hearing aid (s)? _____

Have the aids been satisfactory or unsatisfactory and why? _____

How many hours per day are they worn? _____

How often do you replace batteries? _____