CHILDREN'S HISTORY FORM

PROFESSIONAL SPEECH & HEARING SPECIALISTS

Name of Child: _____ DOB: _____

Name of Parent 1: _____ DOB: _____

Name of Parent 2: _____ DOB: _____

General Information:

Reason for this visit: _____

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

_____

Does your child's hearing ability seem to fluctuate? _____

Was the onset sudden or gradual? _____

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

Has any action been taken to treat hearing loss in your child? _____

_____

Do you know what may be the cause of the hearing problem? _____

_____

Birth History:

Did your child experience any problems at birth? _____

Did mother have any exposure to viral diseases during pregnancy? _____

List any drugs taken during pregnancy: _____

_____

Baby's birth weight: _____ Was your child premature? _____

Indicate if your child experienced the following within the first two weeks following birth:

- ○ Jaundiced at birth
- ○ Jaundiced after 2-3 days
- ○ Convulsions
- ○ Incubator or isolette
- ○ Difficulty breathing
- ○ Transfusions
- ○ Hemmorrhage
- ○ Intravenous fluids
- ○ Infection
- ○ Oxygen
- ○ Feeding difficulty
- ○ Medications

Other: (please describe): _____

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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	○ No	○ Yes	○ If so, when? _____
Tubes placed in ears	○ No	○ Yes	○ If so, when? _____
Dizziness	○ No	○ Yes	○ If so, when? _____
Ringing in ears	○ No	○ Yes	○ If so, when? _____
Pain/discomfort in ears	○ No	○ Yes	○ If so, when? _____
Nausea	○ No	○ Yes	○ If so, when? _____
Head trauma	○ No	○ Yes	○ If so, when? _____
Holes in eardrums	○ No	○ Yes	○ If so, 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?

_____

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

- ○ Chicken pox
- ○ Chronic colds
- ○ Epilepsy
- ○ Influenza
- ○ Meningitis
- ○ Pneumonia
- ○ Tonsilitis
- ○ Asthma
- ○ Mumps
- ○ Allergies

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Speech & 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?

- ○ Sentences
- ○ 3-4 word phrases
- ○ 1-2 word phrases
- ○ Single words
- ○ Points, sounds, crying and noises

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? ○ Yes ○ No If yes, please answer the following:

Does your child wear one now? ○ Yes ○ No 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? _____