



**AUDIOLOGICAL HISTORY**

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender / Sex:  Male  Female

Child resides with:  Both Parents  Mother  Father  Other \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home #: \_\_\_\_\_

Mother's Address: \_\_\_\_\_ Work #: \_\_\_\_\_  
(if different than patient's)

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home #: \_\_\_\_\_

Father's Address: \_\_\_\_\_ Work #: \_\_\_\_\_  
(if different than patient's)

Legal Guardian's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home #: \_\_\_\_\_

Guardian's Address: \_\_\_\_\_ Work #: \_\_\_\_\_  
(if different than patient's)

Insured's Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician (if different): \_\_\_\_\_

Who is with the child today? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

What *specific question(s)* regarding your child's hearing would you like answered today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Audiology & Hearing History**

Do you think your child hears normally?  Yes  No

If no, please explain: \_\_\_\_\_

Did your child pass the newborn hearing screening?  Yes  No

Has your child's hearing been tested before?  Yes  No

If yes, when? \_\_\_\_\_ Results: \_\_\_\_\_

Ear infections as a child?  Yes  No

If yes, first ear infection occurred at what age? \_\_\_\_\_

Ventilation tubes inserted?  Yes  No

If yes, when and by whom? \_\_\_\_\_

### **Has your child had:**

	Yes	No	Explain
Drainage from the ear	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles/Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Noise Exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do any family members have hearing loss? \_\_\_\_\_

Do you feel your child's speech acquisition and language development are progressing normally?

Yes  No If no, please explain \_\_\_\_\_

Has your child ever been prescribed hearing aids?  Yes  No

If yes, please give date of initial fitting: \_\_\_\_\_



**Do you have any *other* Ears, Nose, and Throat concerns regarding your child?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Thank you!* ☺