CHILD HISTORY FORM (Audiologic Evaluation)

Child's Name ______________________________ Birth Date ______________

Parent's/Guardian's Name ______________________________

School ______________________________ Grade ______________

OTHER CHILDREN IN FAMILY

Name ____________________ Age _____ Sex _____ School ____________ Grade Reached ________

Name ____________________ Age _____ Sex _____ School ____________ Grade Reached ________

Name ____________________ Age _____ Sex _____ School ____________ Grade Reached ________

HEALTH OF MOTHER DURING PREGNANCY

1) Any unusual illness? (Measles, RH Blood Factor, Etc.) ☐ Yes ☐ No

If YES, explain: ______________________________

2) Pregnancy__________months Labor hours ________ Birth weight ________lbs ________oz

Select any of the following which apply:

☐ Breech birth ☐ Instruments used ☐ Cesarean section ☐ Trouble breathing ☐ Dry birth ☐ Incubator used

☐ Unusual color at birth ☐ Unusual scars or bruises

HEALTH AND DEVELOPMENT OF THE CHILD

Age sat alone ________ Age walked alone ________ Age toilet training began ________ Age toilet training completed________

Child's physical development has been: ☐ Fast ☐ Normal ☐ Slow Coordination: ☐ Good ☐ Clumsy

Previous hospitalization ☐ Yes ☐ No

Difficulty swallowing or choking ☐ Yes ☐ No

Eye problems ☐ Yes ☐ No

Any serious illnesses ☐ Yes ☐ No

History of high fevers ☐ Yes ☐ No

History of seizures or convulsions ☐ Yes ☐ No

Any serious accidents ☐ Yes ☐ No

Any surgical operations ☐ Yes ☐ No

Have tonsils or adenoids been removed? ☐ Yes ☐ No

Does child have frequent colds, sore throats, or earaches? ☐ Yes ☐ No

Has child ever lost consciousness? ☐ Yes ☐ No

If there are any other medical or behavior problems not listed above, please describe briefly here:

HEARING AND SPEECH/LANGUAGE HISTORY

Has child been seen professionally by anyone for speech, language, or hearing? ☐ Yes ☐ No

If YES, what type?____

Who___________________ Where ___________________ When ___________________

Has child been seen for any other diagnosis or therapy? ☐ Yes ☐ No

When were you first concerned about the child's speech, language, or hearing problems?

What do you feel are some reasons for your child's speech, language, or hearing problems?

Was the onset of your child's hearing loss: ☐ Sudden ☐ Gradual

Date of child's last hearing evaluation and general findings ___________________

Does child have a history of:

☐ Earaches ☐ Dizziness ☐ Ear infections ☐ Ear surgery ☐ Drainage ☐ Head injury ☐ Ringing in the ears ☐ Noise exposure

Does the child have any previous experience with hearing aids? ☐ Yes ☐ No

How long? ___________________ ☐ Right Ear ☐ Left Ear ☐ Both Ears

Age babbling began __________ Age child used first words __________ Note actual words ___________________

Age child began to combine words __________ Was the child responsive as an infant (smile or cry appropriately)? ☐ Yes ☐ No

Can child be understood by parents? ☐ Yes ☐ No

Can child be understood by relatives? ☐ Yes ☐ No

Can child be understood by strangers? ☐ Yes ☐ No

Can child be understood by children? ☐ Yes ☐ No

Does any other member of the family have a speech or hearing problem? ☐ Yes ☐ No

If YES, briefly describe: ____

How is the child doing academically? ____