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Alliance Hearing Center LLC /Alliance Hearing Aids LLC

PEDIATRIC AUDIOLOGY HISTORY FORM

Child's Name: _____ **DOB:** _____

Mother's Name: _____ **Father's Name:** _____ **Today's Date:** _____

How did you hear of us? _____

1. **Were there any problems during the child's pregnancy?** Yes No
   If yes, please explain: _____
2. **Were there any problems during or immediately after child's birth?** Yes No
   If yes, please explain: _____
3. **Did your child pass a newborn hearing screening?** Yes No
   If no, please explain: _____
4. **Does your child have a speech and language delay?** Yes No
   If yes, please explain: _____
5. **Is your child receiving speech language therapy?** Yes No
   If yes, please explain: _____
6. **Are there any other developmental delays you are concerned about?(behavioral, motoric, etc.)** Yes No
   If yes, please explain: _____
7. **Does your child have a history of recurrent ear infections?** Yes No
   If yes, when was the last infection? _____
8. **Has your child had any serious illness such as meningitis, mumps, scarlet fever, very high fever?** Yes No
   If yes, please give details: _____
9. **Was your child ever hospitalized for an illness?** Yes No
   If yes, please give details including medications administered: _____
   _____
10. **Is there a history of hearing loss in the family?** Yes No
    If yes, please give details: _____
    _____
11. **Has your child ever had a head injury causing a concussion or loss of consciousness?** Yes No
    If yes, please give details: _____
    _____
12. **Has your child ever been exposed to loud noise or music such as: .....** Yes No
    Loud Music w/earbuds or speakers, bands, concerts, firearms, snowmobiles, dirt bikes, power tools, car races?
13. **Does your child appear to hear the phone ringing or the doorbell?** Yes No
14. **Does your child startle to loud sounds?** Yes No
15. **Does your child listen to the TV or radio at a loud volume setting?** Yes No
16. **Does your child normally speak loudly?** Yes No
17. **Does your child react to loud sounds by crying or covering his/her ears?** Yes No
18. **Does your child respond when you call him/her from another room?** Yes No
19. **Is your child currently taking any medications?** Yes No
    If yes, please list: _____
20. **Has your child recently seen or is scheduled to see an Ear, Nose and Throat doctor?** Yes No
    If yes, who and when? _____
21. **What are your concerns about your child's hearing?** _____

_____