

AUDIOLOGY CLINIC
PEDIATRIC HISTORY FORM

Date: ___/___/___ Patient's Name: _____
Age: _____ Corrected Age: _____ Referral Source: _____
Parent(s) names: _____ Reason for visit: _____

HEARING HISTORY:

- Parental concern about hearing? _____
- Hearing loss / prior audios: _____
- Newborn hearing screening: _____ Birth Hospital _____
- Family history hearing loss: _____

AUDITORY BEHAVIOR:

- Startles to loud sound Quiets to speech/music Responds to "no"/name (9 mo. +)
- Awakens to loud sound Turns to speech/sound (4-7 mo.) Follows directions (18 mo. +)

OTOLOGIC HISTORY:

- Ear infections/drainage:
Number of episodes: _____ Last episode: _____
Medications: _____ PE tubes: _____
- Ear pain/fullness/pressure

DEVELOPMENTAL MILESTONES:

- On target Delayed Developmental level: _____
- Age sate without support: _____ Age walked without support: _____

SPEECH AND LANGUAGE:

Number of words: _____ Intelligibility: _____ Age of first word: _____
Using: Cooing Babbling Single words Phrases Sentences
Receptive language: _____ Language(s) in home: _____
Speech-language eval: _____ Speech-language therapy: _____

OTHER MEDICAL HISTORY:

Pregnancy: No complications Complications: _____
Birth: Full term Premature _____ weeks gestation Birth weight: _____
 High risk: _____
 Syndrome: _____
Vision: Normal Impaired _____
Other: _____

INFANT PROGRAM/SCHOOL:

_____ Teacher: _____
 Infant Daycare Preschool Elementary Middle High school
School performance: _____

REPORTS TO: _____

NOTES:

Signature: _____ Date: ___/___/___