AUDIOLOGY & HEARING SERVICES OF CHARLOTTE
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CHARLOTTE, NC 28226 T: 704-412-7975 F: 888-965-9948

PEDIATRIC HISTORY

Identifying Information

Child's Name: _____ Birth Date: _____ Sex: _____Age: _____
Person Completing Form: _____ Relation to Patient: _____
Date: _____ Daytime Phone: _____ Evening Phone: _____
Address: _____ City: _____
State: ____ Zip Code: _____

Home and Family Information

1st Parent/Guardian's Name: _____ Occupation: _____ Age: _____
2nd Parent/Guardian's Name: _____ Occupation: _____ Age: ____
Child Lives With: _____ Languages Spoken at Home: _____

Other Children in the Family

Name	Age	Sex	Grade Level	Any Speech, Hearing, or Medical Problems?

Referral Information

Who suggested bringing your child to us for care?	__ Doctor __ Counselor/Therapist __ School __ Self __ Friend __ Other Name: _____
What are your main concerns or reasons for this evaluation?	
At what age was your child's problem first noted? By whom?	

Hearing and Ear History

Do you think your child has a hearing loss? __ Yes __ No Describe: Does your child complain of noise in the ears or head? __ Yes __No Describe: Does your child have dizziness or imbalance? __ Yes __ No Describe:

Did your child have hearing screening as a newborn? __ Yes __ No
If YES, what was the outcome? __ Passed __ Referred
Name of hospital where child was born: _____
Age of first ear infection diagnosed by a doctor: ____
Number of ear infections: Aged 0 to 2 ___; Aged 2 to 4 ___; Aged 4 to 6 ___
Last ear infection: Date: _____ Age: ___
Does your child currently have ventilation tubes? __ Yes __ No
Has your child had any ear surgeries? __ Yes __ No
If YES, when? _____
Has your child worn hearing aids, or does s/he? __ Yes __ No
If YES, when were they fit? _____
How many hours per day does your child use hearing aids? _____
Benefit: __ Good __ Fair __ Marginal

Child's Medical History

Please list any serious illnesses, hospitalizations, and/or surgeries: _____
_____

Indicate whether any of the following are applicable to pregnancy and birth history:

__ Prenatal problems
__ Premature birth
__ Blood incompatibility
__ Birth weight of less than 3.3 pounds
__ Bacterial meningitis
__ In utero infections (ex.: rubella, cytomegalovirus, syphilis, herpes, toxoplasmosis)
__ Ototoxic medications, including but not limited to aminoglycosides

Describe:

__ Apgar scores of 0 to 4 at one minute after birth or 0 to 6 at five minutes after birth
__ Elevated bilirubin
__ Other

Indicate whether your child has been diagnosed with any of the following:

__ Hearing loss
__ ADD/ADHD
__ Speech/language disorder
__ Developmental delays
__Mentally retarded
__ Pervasive developmental disorder (PDD) or autism
__ Cerebral palsy or a motor coordination disorder
__ Emotional or psychiatric disorder
__ Other

Who diagnosed your child and when?

Current medications, dosage, and reason: _____
Has your child taken these medications today? __ Yes __ No

Have any other specialists seen your child?

__ Speech/language pathologist
__ Psychologist
__ Developmental pediatric specialist
__ Special education specialist
__ Physical therapist
__ Occupational therapist
__ Behavioral psychologist
__ Other

Describe: