Pediatric Auditory History

Child's name:_____ DOB:_____

Parents:_____ DOE:_____

Parent's Occupation: _____

Child's school:_____ Grade:_____

Referring Physician:_____

HEARING INFORMATION

1) Do you feel that your child has a hearing problem? If so, why?

_____

_____

_____

2) When was the hearing problem first noticed?

_____

3) Does any member of the family have a hearing problem and/or wear a hearing aid?

_____

_____

4) Does the child have a history of ear infections?

_____

5) Describe any previous treatment or testing the child has received regarding his/her ears or hearing:

_____

_____

_____

6) Has the child ever been exposed to a loud noise or explosion?

_____

7) Does the child ever complain about fullness in his/her ears or noise in his/her ears?
_____ YES _____ NO

8) Does the child become confused with which direction a sound is coming from?
_____ YES _____ NO

9) Does the child seem to watch a speaker's face closely for cues as to what is being said?
_____ YES _____ NO

10) Does the child respond to the following:
name_____ loud noises_____ soft noises_____ verbal commands_____ vibrations_____

11) Has your child received any additional services? If so, what services were provided?

_____

_____

_____

PREGNANCY & BIRTH

1) Any unusual illness during pregnancy? (measles, Rh factor, diabetes, toxemia, high blood pressure)
   _____
   _____
   _____
2) Length of pregnancy: _____month/weeks
3) Child's birth weight: _____lbs _____oz.
4) Circle any of the following which apply:

   breech birth ☐ incubator used ☐ instruments used ☐ trouble ☐

   breathing ☐ C-section: planned or emergency ☐ discoloration ☐

5) History of miscarriage: _____YES _____NO How many?_____
6) Newborn Hearing Screening: _____Pass Left _____Pass Right _____Pass Both

DEVELOPMENTAL INFORMATION

Milestones met: _____Delayed _____On Time _____Early
Child's physical development has been: _____Fast _____Slow _____Normal
Which hand does the child prefer to use? _____Left _____Right

SPEECH/LANGUAGE INFORMATION

1) Did the child smile and cry appropriately as an infant?_____
2) At what age did the child do the following:
   Babble_____ Use words_____ Use phrases_____
3) Have you had any concern regarding the child's speech and language development?
   If so, at what age did you first become concerned?_____
4) Do any family members have speech difficulties? If yes, describe:
   _____
   _____
   _____
5) Is the child aware of his/her communication problem?_____
6) Do you think the child is behind in other areas? If yes, describe:
   _____
   _____
   _____
7) **How** do you communicate with the child? _____
8) Can the child follow simple verbal instructions?_____
9) How does the child make his/her needs known to you?
   _____
   _____