Albuquerque **Speech Language Hearing** Center

Audiology Pediatric History

Name of Patient (Printed)____Today's Date ______________

Name of person filling out the form: ____Relationship ______________

What is the reason for your child's visit today? ____

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What health conditions does your child have and what medications are they taking? ___________________________

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Do you think your child has trouble hearing?	YES ________	NO ________
Has anyone else suggested your child may have trouble hearing?	YES ________	NO ________
Did your child pass a newborn hearing screening?	YES ________	NO ________
Were there any complications with the pregnancy or birth?	YES ________	NO ________
Was your child born early?	YES ________	NO ________
Does anyone related to your child have a hearing loss?	YES ________	NO ________
Does anyone smoke in the home?	YES ________	NO ________
Has your child had any serious illnesses or injuries?	YES ________	NO ________
Has your child been diagnosed with a syndrome?	YES ________	NO ________
Has your child had ear infections?	YES ________	NO ________
Does your child have allergies?	YES ________	NO ________
Has your child been seen by an ear specialist (ENT)?	YES ________	NO ________
Does your child have an upcoming appointment with an ENT?	YES ________	NO ________
Has your child had ear surgery?	YES ________	NO ________
Has your child had ear drainage?	YES ________	NO ________
Is your child's speech appropriate for his or her age?	YES ________	NO ________
Is your child meeting gross motor milestones?	YES ________	NO ________
Is your child receiving any special services?	YES ________	NO ________
Does your child snore?	YES ________	NO ________

If you answered "YES" to any of the above questions, please explain.

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