Albuquerque **Speech Language Hearing** Center

Be a part of the conversation.℠

Audiology Pediatric History

Name of patient (printed) _____ Today's date _____

Name of person filling out the form _____ Relationship _____

How did you hear about us? _____

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

_____

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

_____

_____

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.

_____

_____

_____