Hearing Resource Center of San Mateo
100 S. Ellsworth Ave, Ste 303 & 711
San Mateo, CA 94401
(650) 579-4470
(650) 579-4471 fax

PEDIATRIC MEDICAL HISTORY

Date: _____

Name: _____DOB:_____ Age: _____

Please complete this form to the best of your ability so the Audiologist will better understand your child's health and your concerns. Thank you.

Why is your child having a hearing test? _____

Name of accompanying adult(s) and relation_____

_____

HEARING HISTORY:

Please circle "No" or "Yes" for the following questions. If "Yes" please describe in the space provided.

N	Y	Do you have concerns about your child's hearing? Please describe:
N	Y	Did your child PASS the newborn hearing screening? Leave blank if unknown.
N	Y	Does your child demonstrate any of the following hearing abilities? Please check all that apply. ☐ Startles to loud sounds ☐ Turns to your voice ☐ Enjoys music ☐ Knows his/her name ☐ Will come if called from another room ☐ Points to body parts ☐ Follows simple directions (e.g., pick up your toy, go get your shoes) ☐ Answers questions (e.g., are you hungry, do you want to go outside)
N	Y	Does your child use hearing aids? Began when:

OTOLOGIC HISTORY:

Please circle "Yes" if your child is currently experiencing or has ever had any of the following symptoms. If so, please describe in the space provided.

N	Y	Ear infections? If so, how many? When was the last infection?
N	Y	Drainage from the ears? When:
N	Y	Ear surgery (including tubes)? When:
N	Y	Do you have concerns about your child's balance (e.g., bumps into things)?

FAMILY HISTORY:

Please circle "No" or "Yes" for question below. If "Yes", please describe in the space provided.

N	Y	Do you have family members of ***any*** age with hearing loss? Please describe:

DEVELOPMENTAL HISTORY:
Please circle "Yes" if there are concerns regarding your child's development in any of the following areas. If "Yes", please describe the condition and any evaluation/therapy space provided.

N	Y	Motor / Muscle / Physical? Please describe:
N	Y	Speech / Language? Please describe:
N	Y	Cognitive / Learning? Please describe:
N	Y	Social / Play? Please describe:
N	Y	Behavior / Attention? Please describe:

How would you rate your child's general health? Excellent Good Fair Poor

MAJOR CONDITIONS, SPECIALISTS, SURGERIES, ETC: _____

_____

ALLERGIES (Environmental, Food, Medications): _____

CURRENT MEDICATIONS: _____

MEDICAL HISTORY:
Please circle "No" or "Yes" for the following questions. If "Yes" please describe in the space provided.

N	Y	Did you experience any pregnancy complications (e.g., gestational diabetes, toxemia, etc.) or intrauterine infections (e.g., CMV, herpes simplex, rubella, etc.)? Please describe:
N	Y	Did you experience any complications during labor and delivery? Please describe:
N	Y	Was your child born prematurely? # weeks gestation:
N	Y	Was delivery normal, vaginal?
N	Y	Did your child have to stay in the hospital NICU after birth? # Days: Reason:
N	Y	Did your child have any jaundice (yellowing of the skin or eyes) at birth? Treatment:
N	Y	Has your child ever been on ventilation (oxygen) for an extended period of time? Reason:
N	Y	Has your child ever had any of the following conditions? Please circle all that apply. CMV, RSV, encephalitis, meningitis, chicken pox, mumps, measles
N	Y	Has your child ever had a head or neck injury? When: Please describe:
N	Y	Do you have any concerns regarding your child's vision?