PEE DEE HEARING CENTER

PEDIATRIC HISTORY FORM

(6 months – 18 years)

Child's Name: _____ Date: _____

Age: _____ DOB: _____ Gender: _____ Current grade in school: _____

How much screen time (TV, tablet, or phone) does your child get at home each day?
___ none ___ less than 1 hour ___ 1 to 2 hours ___ more than 2 hours

How much screen time (TV, tablet, or phone) does your child get at daycare/school each day?
___ none ___ less than 1 hour ___ 1 to 2 hours ___ more than 2 hours

I. Statement of Problem

Describe as completely as possible the reported speech, language, and/or hearing problems.

_____

_____

When was the problem first noticed and what do you think caused it? _____

_____

How has the problem changed since you first noticed it? _____

_____

Tell us more about previous or current provided services:

☐ Audiology	☐ Speech therapy
☐ Occupational therapy	☐ Physical therapy
☐ Child Protective Services	☐ Psychological/Counseling services
☐ Other	☐ Public school

II. Prenatal and Birth History

Please check if any of the following were present during pregnancy or birth.

A. Pregnancy ☐ Full term ☐ Premature Number of weeks gestation: _____

☐ Excessive bleeding	☐ German measles	☐ Mother – bed rest
☐ High blood pressure	☐ Diabetes	☐ Smoking
☐ Previous miscarriage	☐ RH incompatibility	☐ Brain injury
☐ Toxemia	☐ X-ray treatment	☐ Serious accident
☐ Premature membrane/Rupture	☐ Mother- alcohol use/abuse	☐ Mother – drug use /abuse

B. Birth ☐ Vaginal ☐ C-Section ☐ Breech

☐ Breathing problems	☐ Jaundice	☐ Extended hospital or NICU stay
☐ Incubator	☐ Cyanosis	☐ Seizures
☐ Injury	☐ Deformity	☐ Infection
☐ Anoxia	☐ Difficult delivery	☐ Feeding/swallowing/sucking difficulty
☐ Cleft/lip palate	☐ Ear tag or Ear pits	☐ Physical Abnormality Specify _____

Explain any other complications related to pregnancy or birth _____

_____

III. Child Development

A. Motor development ☐ delayed ☐ normal ☐ advanced

1. At what age did your child crawl? _____ sit up alone? _____ walk alone? _____
2. Did he/she start, but then stop doing any of the above? ___ No ___Yes. If yes, at what age? _____

B. Speech and Language Development ☐ delayed ☐ normal ☐ advanced

1. How does your child tell you what he/she wants? ☐ Non-verbal ☐ Words/Phrases/Sentences ☐ Eye Gaze/ Gestures / Pointing /Sign Language ☐ Other (Explain)_____
2. What percent of your child's speech do you understand? ___0% ___25 – 50% ___100%
3. What percent of your child's speech would a stranger understand? ___0% ___25 – 50% ___100%

C. Emotional and Behavioral

Check if any of the following apply:

Behavior	**Home**	**School**	**Other *(Specify)***
Behavior problems (destructive, aggressive) _____			
High activity level for age			
Difficulty following directions			
Difficulty maintaining attention. Easily distracted *by*: _____			
Impulsivity (not thinking before acting)			
Difficulty playing/getting along with others			
Prefers to play by himself/herself (shy)			
Problems with adult authority			
Overly sensitive to stimuli _____			
Low response to stimuli			

IV. Medical/Hearing History

Illnesses/Conditions

Check those that apply:

☐ Allergies	☐ Head injury
☐ Attention Deficit Disorder (ADD/ADHD)	☐ High fevers
☐ Autism Spectrum	☐ Hoarseness
☐ Brain injury	☐ Lengthy medication treatment
☐ Cerebral palsy	☐ Measles
☐ Cleft palate/Cleft lip	☐ Mental Health Issues
☐ Cognitive Disorder (memory)	☐ Other surgery/injury:
☐ Down Syndrome	☐ Physical abnormalities: _____
☐ Dyslexia	☐ Seizures
☐ Eating/Feeding/Digestive/Swallowing problems	☐ Sensory-integration disorder
☐ Encephalitis	☐ Syndrome (other): _____
☐ Falls frequently/balance difficulties	☐ Tonsillectomy and/or Adenoidectomy
☐ Frequent colds	☐ Vision Issues? _____ Glasses? _____

1. What current medication is he/she taking? _____
2. Does your child receive vaccinations per the current CDC guidelines? ___ No ___Yes. If no, please explain.

_____

V. Audiological History

1. Did your child pass the first of final newborn hearing screening at birth? ☐ Passed both ☐ Failed both ☐ Passed right ear failed left ear ☐ Passed left ear failed right ear ☐ Unknown results.
2. Do you feel your child's hearing is: stable (stays the same all the time) or fluctuates (comes and goes)?
3. Does your child have a history of cerumen (wax) build up? ___ No ___Yes.
4. Does your child ever complain of ear pain, pressure, or fullness (feeling plugged up)? ___ No ___Yes. If yes, which ear and how often? _____
5. Has he ever been exposed to loud noises (guns, fireworks, loud music, etc.)? ___ No ___Yes.
6. Does your child have a history of ear infections? ___ No ___Yes. If yes, how many ear infections have they had? _____
7. Have tubes been placed in your child's ears or has your child had other ear surgeries? Yes No If yes, how many sets of tubes or types of ear surgery? _____
8. Was anyone in the child's family diagnosed with hearing loss before 30 years old? ___ No ___Yes. If yes, who in the family has hearing loss, and at what age? _____
9. Does your child complain of noises in his/her ears? (ringing, buzzing, roaring) ___ No ___Yes.
10. Does your child have a history of dizziness, imbalance, or falling? ___ No ___Yes.
11. Has your child's hearing been tested before by an audiologist? ___ No ___Yes. If yes, when was the last hearing test? _____Where? _____ Results:_____
12. Does your child currently wear hearing aids? ___ No ___Yes. If yes, what kind and how old are the current aid(s)? _____

VI. Academic History

Current School: ☐ Daycare/Nursery ☐ Preschool ☐ Kindergarten ☐ Middle School ☐ High School

Name of School: _____

Academic Performance: ☐ Below Average ☐ Average ☐ Above Average

1. Has your child been held back or repeated a grade? ___ No ___Yes. If yes, what grade? _____
2. Has your child been tested to address developmental, learning, or speech-language difficulties? ___ No ___Yes. If yes, explain the results: _____
3. Does your child receive any services or modifications/accommodations at school? ___ No ___Yes. If yes, please explain. _____
4. Does your child learn easier using a particular style of learning? ☐ Auditory (Listening/hearing) ☐ Visual (Seeing) ☐ Kinesthetic (Doing/hands-on)

Please give any additional information that will help us in evaluating your child: _____

_____

_____

_____ _____ _____

Signature of person completing this form | Relationship to child | Date