# PEDIATRIC MEDICAL HISTORY

Childs Name: _____ Date of Birth: ___/___/___ Age: _____
Chief Complaint: _____ Primary Physician: _____

**Hearing History** **YES** **NO**

1. Do you have concerns about your child's hearing? ☐ ☐
   If yes, briefly explain: _____
2. Is there any family history (blood relation) of hearing loss that began before the age of 30?
   Relation _____ ☐ ☐
3. Does your child wear **hearing aids** or use any **auditory trainer**? ☐ ☐
   (Circle one device, if Yes)

**Pregnancy and Birth History**

1. Was the pregnancy/delivery abnormal in any way? ☐ ☐
   If yes, please briefly explain _____
2. Did your child stay in the NICU for any duration after birth? ☐ ☐
3. Was there a history of drug use or STD during pregnancy? ☐ ☐
   If yes, please briefly explain _____

**Speech/Language History**

1. Do you have any concerns about your child's speech and language? ☐ ☐
   If yes, briefly explain _____
2. Is your child currently or have plans to attend speech therapy? ☐ ☐

**Medical History**

1. Do you have any medical concerns about your child? ☐ ☐
   If yes, briefly explain _____
2. Please mark if your child has had any of the following:

| | | |
|---|---|---|
| Ear infections ___ | Meningitis ___ | Seizures ___ |
| Ear surgery ___ | Measles ___ | Kidney problems ___ |
| Hospitalization ___ | Mumps ___ | Vision problems ___ |
| Head trauma/injury ___ | Chicken pox ___ | Allergies ___ |
| Noise exposure (e.g. farm equipment, loud music) ___ | | Asthma ___ |

3. Is your child experiencing any ear pain? If so, rate from 1 to 10 (10 being most severe) ___
4. Is your child on any daily medications? If so, please list _____
   (If there are multiple medications, please supply a copy)
5. If you are breast feeding, are you taking any daily medications? If so, please list:
   _____
   (If there are multiple medications, please supply a copy)

| **Additional History** | **YES** | **NO** |
|---|---|---|
| 1. Do you have any other concerns about your child? | ☐ | ☐ |
| If yes, briefly explain _____ | | |
| 2. Does your child: | | |
| Play/interact well with other children? | ☐ | ☐ |
| Have attention/concentration difficulties? | ☐ | ☐ |
| Receive any special education services? | ☐ | ☐ |
| Have difficulty in school? | ☐ | ☐ |

Name of school and address: _____

Primary Teacher: _____ Grade: ____

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian's Signature | Relationship | Date |