Abington Audiology & Balance Center
Clarks Summit • Tunkhannock
570-587-3277

Pediatric History Questionnaire

Patient Information

Chart # _____ Date _____

Patient Name _____
First MI Last

Age _____ DOB _____ ○ Male ○ Female

Address _____ Apt # _____

City _____ State _____ ZIP _____ Phone _____

Reason for Appointment _____

Medical History

Did your child have an infection at birth?
○ None ○ Cytomegalovirus ○ Rubella ○ Herpes ○ Syphilis ○ Toxoplasmosis

Did your child have asphyxia or breathing problems at birth? ○ Yes ○ No

Were any blood transfusions given? ○ Yes ○ No

Please describe _____

Was your child in an intensive-care unit? ○ Yes ○ No

Were there any congenital malformations involving the head, neck, or ears? ○ Yes ○ No

What was your child's weight? _____

Was your child born prematurely? ○ Yes ○ No If so, how many weeks? _____

Was your child treated with any antibiotics? ○ Yes ○ No If so, what kind? _____

Did your child ever have meningitis? ○ Yes ○ No If so, at what age? _____

Did your child have elevated bilirubin (jaundice)? ○ Yes ○ No

Is there a family history of hearing problems in early childhood? ○ Yes ○ No
○ Mother ○ Father ○ Grandmother ○ Grandfather ○ Brother
○ Sister ○ Uncle ○ Aunt ○ Cousin ○ Other

Does your child have any other associated disability? ○ Yes ○ No
○ Blindness or vision disorder ○ Cerebral palsy ○ Developmental disability
○ Seizure disorder ○ Down syndrome ○ Learning disability
○ Other _____

When did you last consult a physician about your child's ears? _____

Has your child had any earaches? ○ Yes ○ No If so, which ear(s)? ○ Left ○ Right ○ Both

Have their ears been medically treated? ○ Yes ○ No If so, which ear(s)? ○ Left ○ Right ○ Both

Is your child receiving any medication? ○ Yes ○ No If so, what kind? _____

Has your child experienced dizziness? ○ Yes ○ No

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Hearing and Speech History

Do you think your child has a hearing problem? ○ Yes ○ No

How old was your child when you first noticed a hearing loss? _____

Has your child's hearing been tested before? ○ Yes ○ No

Does your newborn startle at loud sounds? ○ Yes ○ No ○ N/A

Does your three-month-old stop moving or crying when you call them? ○ Yes ○ No ○ N/A

Does your six-month-old enjoy noise-making toys? ○ Yes ○ No ○ N/A

Does your nine-month-old babble frequently? ○ Yes ○ No ○ N/A

Does your one-year-old respond to simple commands? ○ Yes ○ No ○ N/A

At what age did your child first babble? _____

At what age did your child say his/her first word? _____

At what age did your child start speaking short (2- to 3-word) sentences? _____

How many words does your child have in his/her vocabulary? _____

How often does your child use speech? ○ Frequently ○ Occasionally ○ Seldom ○ Never ○ N/A

Is your child's speech clear? ○ Yes ○ No ○ N/A

How did you hear about our services?

○ Doctor's referral ○ Advertisement ○ School
○ Friend ○ Yellow pages ○ Previous patient
○ Other _____

Authorization for Release of Information

I authorize _____ to release any part or all of my records to those persons listed below:

	Name	Address
1.	_____	_____
2.	_____	_____
3.	_____	_____

Signature _____ Date _____

Print Name _____

Relationship to Patient _____