Pediatric Medical History

Patient Name: _____DOB:_____ Today's Date:_____

Person Completing Form: _____ Relation to Child: _____

1. Why are we seeing your child today? _____

2. Do you suspect hearing loss?
   - ☐ Yes - Which ear? _____
   - ☐ No

3. Does your child have any medical issues or syndromes?
   - ☐ Yes - Please explain: _____
   - ☐ No

4. Does your child have any other diagnosed co-morbidities? (Ex: attention deficit disorder, auditory processing disorder, dyslexia, etc)
   - ☐ Yes - Explain: _____
   - ☐ No

5. Referred due to failed hearing screening at hospital, pediatrician's office, school?
   - ☐ Yes - Where? _____ When? _____
   - ☐ No

6. Pain or tugging from ears?
   - ☐ Yes Which ear(s): _____
   - ☐ No

7. History of middle ear infections?
   - ☐ Yes -Date of last infection: _____ Which ear(s):_____
   - ☐ No

8. History of PE tubes?
   - ☐ Yes When? _____Which ear(s): _____
   - ☐ No

9. Sinus/allergy problems?
   - ☐ Yes
   - ☐ No

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10. Recent cold or influenza?
    - ☐ Yes When? _____
    - ☐ No
11. Medications-please list: _____
12. Family history of hearing loss?
    - ☐ Yes- Who? _____
    - ☐ No
13. Birth or delivery complications?
    - ☐ None
    - ☐ Jaundice
    - ☐ Premature
    - ☐ Illness
    - ☐ NICU
    - ☐ Ventilator
    - ☐ C-Section
    - ☐ Other :_____
14. Has your child ever tested positive for COVID-19?
    - ☐ Yes - When? _____
    - ☐ No
15. Was the child's mother diagnosed with COVID-19 during pregnancy?
    - ☐ Yes
    - ☐ No
16. Does the child currently have a history of speech/language delays?
    - ☐ Yes: _____ Intervention/therapy?_____
    - ☐ No
17. Developmental delays?
    - ☐ Yes: _____
    - ☐ No
18 . School/Academic Performance?
    - ☐ Below Average
    - ☐ Average
    - ☐ Above Average