LAKESIDE AUDIOLOGY
Hearing Solutions for All

Pediatric Audiology History

Patient Name: _____ **Date of Birth:** _____

Pediatrician: _____

Do you have any concerns about your child's hearing? Yes ☐ No ☐
If yes, please describe concerns:

_____

_____

Have any family members, or your child's teacher, expressed concerns about their hearing? Yes ☐ No ☐
If yes, please describe concerns:

_____

_____

Do any of your child's relatives have hearing problems? Yes ☐ No ☐
If yes, please describe who and what age it was identified:

_____

_____

At what age did your child speak their first words? _____

Do you feel your child is developing speech & language skills normally? Yes ☐ No ☐

Does your child currently receive any therapy services (Speech, Occupational, PT, etc.)? Yes ☐ No ☐

If yes, please describe therapy type, how long they have been going, and how often they go:

_____

_____

MEDICAL HISTORY:

Has your child been diagnosed with any of the following conditions? *Check all that apply.*

☐ Speech/Language Delays ☐ Autism Spectrum Disorder ☐ Hearing Loss
☐ Learning Disabilities ☐ ADHD

Please describe any other conditions or medical history not listed:

_____

_____

_____

Please list any surgical procedures & dates:

_____

_____

_____

Please list any medications your child is currently taking:

_____

_____

PRE-NATAL HISTORY:

Was your child born full term? Yes ☐ No ☐ **How Many Weeks: _____ Birthweight: _____**

Did any of the following conditions occur during their pregnancy? ***Check all that apply.***

☐ CMV ☐ Substance/Alcohol abuse ☐ Infections

☐ Lack of Oxygen ☐ Communicable Diseases ☐ Other: _____

Were there any complications during their pregnancy? Yes ☐ No ☐

If yes, please describe complications:

_____

_____

Did any of these conditions occur during their labor & delivery or hospital stay? ***Check all that apply.***

☐ Cesarean ☐ Congenital defects ☐ Medication given to child

☐ Neonatal Care in NICU ☐ Jaundice ☐ Ventilator

☐ Low APGAR score ☐ Received blood transfusion ☐ Lack of Oxygen

Did your child pass their Newborn Hearing Screening? Yes ☐ No ☐

Was your child able to go home from the hospital with you? Yes ☐ No ☐

If no, please describe why:

_____

_____

EARS:

Has your child had a history of ear infections? Yes ☐ No ☐ **How many within past 6 months?** _____

If yes, please describe treatment:

_____

_____

IN-OFFICE USE ONLY:

	SRT / SAT	.5	1	2	4
R					
L					
BC					
SF					

	R	L
ECV		
Adm		
daPa		
Reflex		

TDH / INSERTS / SPEAKERS
BOA / VRA / CPA / Conventional
Excellent / Good / Fair / Poor
Team