Child Medical History

Reason for Referral (Statement of problem)_____
_____
_____

Y N

1. Has your child ever had his/her hearing tested before? (Dates, by whom, Results):_____
_____
_____

Y N

2. Has your child ever had episodes of earaches or ear infections?
Right Ear Left Ear
(When/Treatment/Treating Physician):_____
_____
_____

Y N

3. Has your child ever had ear surgery?
Right Ear Left Ear
(When/Type of Surgery/Physician):_____
_____
_____

Y N

4. Has your child ever been hospitalized?
(Date/Reason/Treatment/Physician)
_____
_____
_____

Y N

5. Does your child have any known medical problems or disabilities, whether Physical, intellectual, or developmental? (Please describe or provide diagnosis, age of child when first observed or diagnosed, treatment, physician, etc.):_____
_____
_____
_____
_____

Y N

6. Has your child undergone special educational, developmental, psychological, speech or other similar testing? (When, where, by whom, results, therapy):_____
_____
_____
_____
_____

Child Medical History

Y N

7. Does your child ever complain of buzzing in the ears?
Right Ear Left Ear
Constant Intermittent Sudden Onset Gradual Onset
Date First Noticed:_____Describe Noise:_____
_____

Y N

8. Has your child ever had episodes of dizziness or balance problems? (Date, treatment, physician):_____
_____
_____

Y N

9. Has your child ever had an illness which you suspect affected his/her hearing? (Dates, diagnosis, treatment, physician:_____
_____
_____

Y N

10. Has your child ever been rendered unconscious from a fall or blow to the head? (Date, treatment, physician):_____
_____
_____

Y N

11. Are there any relatives with known hearing loss? (Relationship, age of hearing loss onset, diagnosis, treatment):_____
_____
_____

Y N

12. Has your child ever been exposed to levels of high noise? (Guns, firecrackers, loud music etc.) Explain:_____
_____
_____

Y N

13. Does your child wear a hearing aid?
Right Ear Left Ear
Present Models_____Purchase Date_____
Dispenser's Name_____City_____
Opinion/Problems_____
_____
_____

Child Medical History

14. Please circle any of the following medical problems that your child has had:

	Age
Allergies---------	_____
Chicken Pox------	_____
Measles--------	_____
Mumps-------	_____
Scarlet Fever----	_____
Meningitis-----	_____
Seizures-----	_____
Learning problems--	_____
Hyperactivity-----	_____
Pneumonia-----	_____
High Fevers (103)---	_____

15. Please provide any medical information that you feel may be relevant:

_____
_____
_____
_____
_____
_____
_____
_____