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PEDIATRIC HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name _____ Date _____

Age _____ DOB _____ Gender _____

Reason for Visit _____

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

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

Did your child pass his or her newborn hearing screening? _____ Yes _____ No

Is there a family history of hearing loss 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)? _____

Have your child's ears been medically treated? _____ Yes _____ No

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

Has your child experienced dizziness? _____ Yes _____ No

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

Does your three-month-old stop moving or crying when you call him/her? _____ Yes _____ No

Does your six-month-old enjoy noise-making toys? _____ Yes _____ No

Does your nine-month-old babble frequently? _____ Yes _____ No

Does your one-year-old respond to simple commands? _____ Yes _____ No

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 (2-3 word) sentences? _____

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

How often does your child use speech? _____

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