



**Audiology Department History Form-Child**

Date: \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Child's name: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

\_\_\_\_\_

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Parent's home phone: \_\_\_\_\_

Parent's cell phone: \_\_\_\_\_

Hospital of birth: \_\_\_\_\_

Why was a hearing test requested? \_\_\_\_\_

\_\_\_\_\_

Has your child had any of the following:

earaches/ear infections	yes	no	tonsillitis	yes	no
chronic colds	yes	no	ear tubes	yes	no
allergies	yes	no	speech delay	yes	no
running ears	yes	no	learning problems	yes	no
fluid in the ears	yes	no	head injuries	yes	no

Is your child taking any medications? Please list: \_\_\_\_\_

\_\_\_\_\_

Describe any surgeries or hospital stays your child has had

When:

Where done:

Procedure performed:

Doctor's name:

Is there a family history of hearing problems? Please describe \_\_\_\_\_

\_\_\_\_\_

Please bring this completed form to your hearing test appointment