NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY – CHILD**

WILL THIS BE YOUR CHILD’S FIRST HEARING TEST?......................................... YES\_\_\_\_ NO\_\_\_\_

HAS YOUR CHILD SEEN A DOCTOR IN THE PAST 6 MONTHS?.......................... YES\_\_\_\_ NO\_\_\_\_

IS HE/SHE CURRENTLY UNDER A PHYSICIAN’S CARE?...................................... YES\_\_\_\_ NO\_\_\_\_

DESCRIBE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO IS YOUR CHILD’S PHYSICIAN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS HE/SHE TAKING ANY MEDICATIONS?........................................................... YES\_\_\_\_ NO\_\_\_\_

PLEASE LIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE A HISTORY OF HEARING LOSS IN YOUR FAMILY?.............................. YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?:

TENDANCY TO PULL ON EARS…………………………………………………………. YES\_\_\_\_ NO\_\_\_\_

KIDNEY PROBLEMS…………………………………………………………………………. YES\_\_\_\_ NO\_\_\_\_

EAR PAIN……………………………………………………………………………………….. YES\_\_\_\_ NO\_\_\_\_

MIDDLE EAR INFECTIONS/EAR DRAINAGE/FLUID BUILD UP……………. YES\_\_\_\_ NO\_\_\_\_

DEFORMITY OF THE EAR…………………………………………………………………. YES\_\_\_\_ NO\_\_\_\_

HIGH FEVERS………………………………………………………………………………….. YES\_\_\_\_ NO\_\_\_\_

WERE THERE ANY COMPLICATIONS WITH PREGNANCY, DELIVERY, OR BIRTH YES\_\_\_\_ NO\_\_\_\_

IF YES, PLEASE EXPLAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL DISEASES, INFECTIONS AND HIGH FEVERS YOUR CHILD HAS HAD

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE AT WHICH YOUR CHILD DEMONSTRATED THE FOLLOWING:

USED FIRST MEANINGFUL WORDS………………………………. \_\_\_\_\_\_

USED SHORT TWO TO THREE WORD PHRASES…………….. \_\_\_\_\_\_

**HEARING HISTORY**

WHEN DID YOU FIRST NOTICE YOUR CHILD’S DIFFICULTY HEARING?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAN YOUR CHILD BE UNDERSTOOD BY OTHERS?........................................... YES\_\_\_\_ NO\_\_\_\_

CAN YOU UNDERSTAND YOUR CHILD’S SPEECH?........................................... YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD TALK TO GET WHAT HE/SHE WANTS?.............................. YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD TALK LOUDLY?.................................................................. YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD HEAR YOU WHEN YOU CALL?........................................... YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD RESPOND TO MOST SOUNDS?.......................................... YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD FREQUENTLY ASK YOU TO REPEAT THINGS?.................... YES\_\_\_\_ NO\_\_\_\_

IS YOUR CHILD HAVING DIFFICULTY IN SCHOOL?........................................... YES\_\_\_\_ NO\_\_\_\_

IF YES, PLEASE EXPLAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THE TV LOUD WHEN YOUR CHILD WATCHES IT?........................................ YES\_\_\_\_ NO\_\_\_\_

CAN YOUR CHILD HEAR THE TELEPHONE RING?............................................ YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD HAVE TROUBLE HEARING ON THE TELEPHONE?............. YES\_\_\_\_ NO\_\_\_\_

DOES YOUR CHILD HAVE A HEARING AID?.................................................... YES\_\_\_\_ NO\_\_\_\_