OKLAHOMA HEARING CENTER

CHILD AUDIOLOGY HISTORY

DATE: _____ ACCT#: _____
NAME: _____ DATE OF BIRTH:_____
NAME OF PERSON FILLING OUT THIS FORM: _____

HISTORY QUESTIONNAIRE

WHAT IS THE CHILD'S PRIMARY LANGUAGE: _____
ENT PHYSICIAN (EAR, NOSE, THROAT): _____
DATE LAST SEEN: _____

FATHER'S FULL NAME: _____
FATHER'S PLACE OF EMPLOYMENT: _____
BUSINESS ADDRESS: _____
POSITION: _____ BUSINESS TELPHONE: _____

MOTHER'S FULL NAME: _____
MOTHER'S PLACE OF EMPLOYMENT: _____
BUSINESS ADDRESS: _____
POSITION: _____ BUSINESS TELEPHONE: _____

WHO HAS LEGAL CUSTODY OF THIS CHILD? _____
(NAME)

_____
(ADDRESS AND PHONE NUMBER)

PREGNANCY AND BIRTH

LENGTH OF PREGNANCY: _____

DURING THE PREGNANCY, WERE THERE ANY UNUSUAL CONDITONS SUCH AS ILLNESS, MEDICATIONS, X-RAYS, BLOOD INCOMPATIBILITY, SERIOUS ACCIDENTS, FALSE LABOR, THREATENED MISCARRIAGE, OR SUBSTANCE ABUSE? (If yes, please describe)

_____
_____
_____
_____

WERE THERE ANY UNUSUAL CONDITIONS AT OR IMMEDIATELY FOLLOWING BIRTH?
(Circle all that apply)

SUCKING/SWALLOWING DIFFICULTIES	LOW BIRTHWEIGHT	SEIZURES
FEEDING PROBLEMS	BIRTH DEFECTS	SILENT BABY
BREATHING PROBLEMS	SLUGGISHNESS	NICU STAY
RESPIRATORY PROBLEMS	C-SECTION DELIVERY	YELLOW COLOR / JAUNDICE
LOW APGAR SCORE	OXYGEN GIVEN	

PATIENT MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

CYTOMEGALIC VIRUS	ALLERGIES	RUBELLA
EARACHES	MOUTH BREATHER	MEASLES
P.E. TUBES IN EARS	MENINGITIS	MUMPS
PHYSICAL DISABILITES	HIGH FEVER	ABUSED
WHOOPING COUGH	CHICKEN POX	

DESCRIBE ANY MAJOR ILLNESSES/ ACCIDENTS/ SURGERIES:

_____
_____
_____

DOES ANYONE IN YOUR FAMILY HAVE HEARING LOSS? _____
FAMILY PHYSICIAN: _____

CHILD'S EDUCATION

NAME OF SCHOOL: _____
CURRENT GRADE LEVEL: _____

SPECIAL SERVICES RECEIVED (LABS, TUTORING, REMEDIAL INSTRUCTION, SPEECH THERAPY, SPECIAL CLASSES, IPE, TESTING, GRADES REPEATED):

_____
_____
_____

SPEECH / LANGUAGE / LEARNING DEVELOPMENT

DID YOU CHILD BABBLE AND COO DURING FIRST 6-9 MONTHS? _____

AT WHAT AGE:
DID YOUR CHILD FIRST SPEAK? _____
USE OTHER WORDS? _____
PUT WORDS TOGETHER? _____
SAY COMPLETE SENTENCES? _____
DID SPEECH/ LANGUAGE/ READING/ LEARNING EVER SEEM TO STOP? IF SO, WHEN?

_____

HEARING DEVELOPMENT

DID YOUR CHILD PASS THE NEWBORN HEARING SCREENING? _____

HOW DOES YOUR CHILD RESPOND TO SPOKEN DIRECTIONS AND QUESTIONS?

_____

DOES YOUR CHILD RESPOND TO NOISE? IF SO, WHAT KIND AND HOW?

_____

HAS YOUR CHILD EVER WORN HEARING AIDS? IF YES, WHAT TYPE AND FOR HOW LONG?

_____

ONE OR BOTH EARS? _____ IF JUST ONE, WHICH EAR? _____

DOES YOUR CHILD'S HEARING SEEM TO FLUCTUATE? _____

IS THERE ANY OTHER INFORMATION THAT YOU FEEL WOULD HELP IN THIS EVALUATION?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____