MAICO AUDIOLOGICAL SERVICES

PEDIATRIC HISTORY FORM

Child's Name _____ Childs Date of Birth _____

Parent(s) Name _____ Today's Date _____

Reason for your visit _____

Pediatrician or Referring Physician _____

Pregnancy and Birth History:

Yes No

☐ ☐ Full term — Premature: How early _____

☐ ☐ Did your child stay in NICU? — How long? _____

☐ ☐ Did your child have a high bilirubin count? — Required time under lights? ☐ Yes ☐ No

Required blood transfusion? ☐ Yes ☐ No

☐ ☐ Complications during birth or shortly after: _____

Including *(Check all that apply)*: ☐ Asphyxia ☐ Meningitis ☐ Febrile ☐ Cleft palate/lip

☐ ☐ Passed Newborn Hearing Screening — Did not pass: ☐ Right ☐ Left ☐ Both

During Pregnancy Mother Exposed to (check all that apply):

☐ Measles ☐ Mumps ☐ Chicken Pox ☐ German Measles

☐ Alcohol ☐ Smoking ☐ Drugs(Medication/Recreational)

During Pregnancy Mother Diagnosised with (check all that apply):

☐ Syphilis ☐ Herpes Virus ☐ Influenza ☐ Cytomeglovirus (CMV)

☐ Toxoplasmosis ☐ Rh incompatibility ☐ Other _____

Early childhood History and Hospitalization (check all that apply)

☐ Meningitis ☐ Encephalitis ☐ Measles ☐ Influenza (Flu)

☐ Rubella ☐ CMV ☐ Chickenpox ☐ Septicemia

☐ Diabetes ☐ Sickle Cell Disease ☐ Other _____

Child's general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Yes No

☐ ☐ Been seen by an otolaryngologist/ENT — When? _____

Physician's Name: _____

☐ ☐ Repeated ear infections ☐ Right ☐ Left ☐ Both

☐ ☐ PE tubes (in ears) ☐ Right ☐ Left ☐ Both

When? _____

☐ ☐ Allergies — To what? _____

Ear Surgeries ☐ Tympanoplasty ☐ Stapedectomy ☐ Mastoidectomy ☐ Cholestatoma

Brief Family History

☐ Progressive Blindness ☐ Hearing loss

Relationship: _____

Developmental History:

Primary language at home: _____

Other languages used in the home: _____

Developmental milestones ☐ On target ☐ Delayed ☐ Advanced

Child responds to (check all that apply)

☐ Name when called ☐ Questions

☐ Favorite TV show/Movie ☐ Directions

☐ Startles to sounds while resting ☐ Localizes direction sounds come from

Child has been diagnosed with (check all that apply):

☐ Down Syndrome ☐ Cerebral Palsy

☐ Muscular Dystrophy ☐ Vision Problems

☐ Autism Spectrum Disorder ☐ Attention Deficiet Disorder/ADHD

☐ Speech Delay ☐ Language Delay

☐ Devolpmental delay ☐ Learning Disabilities

☐ Other _____

Educational Information (4-18 y/o)

School Name _____ Grade _____

Teacher _____

Type of Classroom ☐ Regular ☐ LD ☐ Self-contained

Does your child have ☐ IEP ☐ 504 Plan

Yes No

☐ ☐ Ever placed in Special Education

☐ ☐ Received hearing/speech/language services

☐ ☐ Other services Explain: _____

☐ ☐ Used FM/Assistive Listening Devices

Amplification Information

Yes No

☐ ☐ Child uses hearing aid(s) ☐ Right ☐ Left ☐ Both

Uses the devices ☐ Regularly ☐ Sometimes ☐ Rarely