

Pediatric History Form Ages 5 and Above
Audiology Department
Braintree Rehabilitation Hospital

Date: _____
Child's Name: _____ D.O. B: _____
Parent/Guardian's Name: _____
Phone Number: _____ Alternate number please: _____
Referring Agent: _____
Do you have a follow-up appointment with this physician? *Yes* *No*
If *yes*, When? _____
Reason for referral: _____
Main Concerns: _____

How long has the problem existed? _____

SCHOOL INFORMATION

1. Name of School: _____
 2. Address: _____
 3. How long attended: _____ Grade: _____ Grade (s) repeated: _____
 4. Number of Children in class: _____
 5. Type of classroom (Traditional, Inclusion, etc.): _____
 6. Does your child have difficulty with any subjects in school? *Yes* *No*
If *yes*, list: _____
 7. What are your child's best subjects in school? _____
 8. Has the child received any of the following therapeutic or remedial services?
 Speech/Language Therapy Counseling
 Physical Therapy Resource Room
 Reading Support Tutoring
 Occupational Therapy Other: _____
 9. Is your child currently receiving any of these services? *Yes* *No*
If *yes*, describe. _____
 10. Has your child had a CORE evaluation performed at school? *Yes* *No*
(If *yes*, please include a copy of all tests completed through the school.)
 11. Is your child currently on an Individualized Education Program (IEP) or a 504
Accommodation Plan? *Yes* *No*
 12. Has your child been seen by specialists outside of school? *Yes* *No*
If *yes*, describe. _____
- _____

OTOLOGIC HISTORY

1. What were the results of your child's Universal Newborn Hearing Screening?
 Passed both ears Referred both ears
 Referred right ear only Referred left ear only
2. How many ear infections has your child had?
 None 1-2 3-5 6-10 10 or more
3. When was his/her last ear infection? _____
4. Does your child have any of the following?
 frequent runny nose frequent colds or sinus infections
 allergies ringing or buzzing in the ear(s)
 dizziness permanent hearing loss
5. Has your child ever been seen by an Ear, Nose, & Throat (ENT) Doctor? *Yes* *No*
If *yes*, which doctor? _____ When? _____
6. Has your child ever had ear surgery? *Yes* *No*
If *yes*, describe. _____
7. Has your child previously had his/her hearing tested by an audiologist? *Yes* *No*
If *yes*, by whom? _____ When? _____
What were the results? _____

DEVELOPMENTAL HISTORY

1. Length of Pregnancy: _____ Birth Weight: _____
2. Were there any complications before or after your child's birth? *Yes* *No*
If *yes*, explain: _____
3. Were there any concerns about your child's early development (i.e., speech and language/motor development)? *Yes* *No*
If *yes*, explain: _____
4. Has your child had any unusual illness or hospitalization? *Yes* *No*
If *yes*, explain: _____
5. Does your child take any medications? *Yes* *No*
If *yes*, please list: _____

KNOWN RISK FACTORS

(Check those that apply)

- Family history of permanent hearing loss in childhood
- Congenital perinatal infection (e.g., cytomegalovirus, rubella, herpes, toxoplasmosis, syphilis)
- Prematurity (length of pregnancy: _____ weeks)
- Hyperbilirubinemia/Jaundice (requiring exchange transfusion)
- ECMO- Extracorporeal membrane oxygenation
- Pulmonary hypertension
- Ototoxic medication (e.g.: gentamicin)
- Confirmed bacterial meningitis
- Trisomy 21 (Down syndrome)
- CHARGE syndrome
- Anatomic malformation of head, face, or neck (e.g., dysmorphic appearance, cleft lip or palate, abnormalities of ear such as microtia, atresia, or periauricular tags/pits)
- Head Trauma requiring hospitalization
- Mucopolysaccharidosis, Type: _____
- Other genetic syndromes associated with hearing loss: _____
- Parental concern
- Speech/language Delay
- Other conditions: _____

RELATED SIGNS AND SYMPTOMS

Handedness?	Right	Left	(circle correct answer)
Is your child easily distracted?			Yes No
Problems hearing in noise or when others are talking?			Yes No
Complains about loud sounds in the environment?			Yes No
Confuses directions or can't follow commands?			Yes No
Asks speaker to repeat (e.g., Says "What?" or "Huh?")			Yes No
Difficulty comprehending verbal instructions?			Yes No
Coordination Problems?			Yes No
Musically inclined?			Yes No
Learning Disability?			Yes No
Reading Problems?			Yes No
Attention Deficit Disorder?			Yes No
Others in family with language/learning problems?			Yes No

Please provide additional information to help us understand your child's strengths and weaknesses. _____
