SILVER STATE
HEARING & BALANCE

Pediatric History Form

Patient Name_____ Date of Birth:_____

1. Birth History
   a. Prenatal Problems ☐Yes ☐No
   b. Premature Birth ☐Yes ☐No
   c. Abnormal Apgar Scores ☐Yes ☐No
   d. Baby in ICU ☐Yes ☐No
   e. Ventilation Required ☐Yes ☐No
   f. Low Birth Weight ☐Yes ☐No
2. Does your child have any current medical conditions? ☐Yes ☐No
   a. If yes, please list_____
3. Is your child currently on any medications? ☐Yes ☐No
   a. If yes, please list_____
4. Does your child have a history of ear infections? ☐Yes ☐No
   a. If yes, how many? _____
5. Has your child ever had tubes placed in his/her eardrums? ☐Yes ☐No
   a. If so, how many sets? _____
6. Do you currently have any concerns regarding your child's hearing? ☐Yes ☐No
7. Has your child ever had their hearing tested? ☐Yes ☐No
   a. If yes, when and where? _____
8. Does your child have any permanent hearing loss you are aware of? ☐Yes ☐No
   a. If yes, does your child use hearing aids? ☐Yes ☐No
9. Is there anyone in your family with hearing loss? ☐Yes ☐No
10. Has your child ever been tested for speech/language delays/difficulties? ☐Yes ☐No
    a. If yes, what was the outcome of the testing? _____
11. Does your child exhibit any of the following behaviors?
    a. Poor attention. ☐Yes ☐No
    b. Sensitivity to loud sounds. ☐Yes ☐No
    c. Problems following directions. ☐Yes ☐No
    d. Appears confused in noisy places. ☐Yes ☐No
    e. Frequently requests repetition. ☐Yes ☐No
    f. Frowns or strains when listening. ☐Yes ☐No
    g. Rarely participates in class discussions. ☐Yes ☐No
    h. Cannot localize sounds. ☐Yes ☐No
    i. Gives inappropriate answers to simple questions. ☐Yes ☐No
    j. Is overly dependent on visual cues. ☐Yes ☐No
    k. Easily frustrated. ☐Yes ☐No
    l. Often speaks too loudly. ☐Yes ☐No
    m. Complains of ringing, buzzing or other noises in the head. ☐Yes ☐No

Parent/Guardian Signature: _____

Date: _____

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