

Pediatric History Questionnaire

Web Use Only

Patient Information

Chart # _____ Date _____

Patient Name _____
First MI Last

Age _____ DOB _____ Gender _____

Address _____ Apt # _____

City _____ State _____ ZIP _____ Phone _____

Reason for Appointment _____

Medical History

Did your child have an infection at birth?

- None Cytomegalovirus Rubella Herpes Syphilis Toxoplasmosis

Did your child have asphyxia or breathing problems at birth? Yes No

Were any blood transfusions given? Yes No

Please describe _____

Was your child in an intensive-care unit? Yes No

Were there any congenital malformations involving the head, neck, or ears? Yes No

What was your child's weight? _____

Was your child born prematurely? Yes No If so, how many weeks? _____

Was your child treated with any antibiotics? Yes No If so, what kind? _____

Did your child ever have meningitis? Yes No If so, at what age? _____

Did your child have elevated bilirubin (jaundice)? Yes No

Is there family history of hearing problems in early childhood? Yes No

- Mother Sister Grandmother Aunt Cousin
 Father Brother Grandfather Uncle Other

Does your child have any other associated disability? Yes No

- Blindness or vision disorder Cerebral palsy Developmental disability
 Seizure disorder Down syndrome Learning disability
 Other _____

When did you last consult a physician about your child's ears? _____

Has your child had any earaches? Yes No If so, which ear(s)? Left Right Both

Have their ears been medically treated? Yes No If so, which ear(s)? Left Right Both

Is your child receiving any medication? Yes No If so, what kind? _____

Has your child experienced dizziness? Yes No

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Hearing and Speech History

Do you think your child has a hearing problem? Yes No

How old was your child when you first noticed a hearing loss? _____

Has your child's hearing been tested before? Yes No

Does your newborn startle at loud sounds? Yes No N/A

Does your 3-month-old stop moving or crying when you call them? Yes No N/A

Does your 6-month-old enjoy noise-making toys? Yes No N/A

Does your 9-month-old babble frequently? Yes No N/A

Does your 1-year-old respond to simple commands? Yes No N/A

At what age did your child first babble? _____

At what age did your child say his/her first word? _____

At what age did your child start speaking short (2- to 3-word) sentences? _____

How many words does your child have in his/her vocabulary? _____

How often does your child use speech? Frequently Occasionally Seldom Never N/A

Is your child's speech clear? Yes No N/A

How did you hear about our services?

Doctor's referral Advertisement School

Friend Yellow pages Previous patient

Other _____

Authorization for Release of Information

I authorize _____ to release any part or all of my records to those persons listed below:

Name	Address
1. _____	_____
2. _____	_____
3. _____	_____

Signature _____ Date _____

Print Name _____

Relationship to Patient _____