Mid-Valley Hearing Center
Pediatric Audiological History

Child's Name:_____
Date:_____

Reason for Visit:_____

1. Do you have concerns about your child's hearing? ☐ Yes ☐ No

2. Does your child have or did have any of the following (please check):

☐ Ear infections	☐ Ear deformity	☐ Sensitivity to loud sounds
☐ Ear surgery	☐ Ear drainage	☐ Genetic disorder
☐ Allergies	☐ Ear pain	☐ Infections before birth
☐ Meningitis	☐ Hyperactivity	☐ Behavioral problems
☐ Head injury	☐ Autism	

3. Did any problems occur during the pregnancy or delivery? ☐ Yes ☐ No
   If Yes, please describe: _____

4. Did your child pass newborn hearing screening? ☐ Yes ☐ No Where?_____
   If No, which ear did not pass? ☐ Right ☐ Left ☐ Both

5. Other than as newborn, has your child's hearing been tested before? ☐ Yes ☐ No
   If Yes, Where? _____
   If Yes, what were the results? _____

6. Has your child met all developmental milestones for his age? ☐ Yes ☐ No
   If No, what areas are delayed? ☐ Gross motor ☐ Fine motor ☐ Speech
   ☐ Cognitive ☐ Social

7. Has your child been tested for speech, motor skills, or other concerns? ☐ Yes ☐ No
   If Yes, what were the results?_____

8. Does your child receive any special services? ☐ Yes ☐ No
   If Yes, please list: _____

9. Does your child have any blood relatives with hearing loss that started before age 30?
   ☐ Yes ☐ No

10. List any medical problems or serious illnesses your child has had:
_____
_____

11. List any medications your child is taking, excluding vitamins:
_____
_____

12. Is there anything else you want us to know about your child? _____
_____