Infant History Questionnaire (0-24 months)

Child's Name ____________________ Age __________

Person Completing Form ____________________ Date __________

Relationship to Child ____________________

Primary Care Physician ____________________

Referring Physician ____________________

Have we seen you at this office before? ☐ Yes ☐ No

Describe problem or reason for this evaluation ____________________

Does your child have a hearing impairment? ☐ Yes ☐ No ☐ Unknown

How long have you noticed this problem? ____________________

Are you concerned about your child's hearing? ☐ Yes ☐ No. If yes, explain ____________________

____

Describe your concerns (check all that apply)

☐ Failed newborn hearing screening ☐ Right ☐ Left ☐ Both

☐ History of hearing loss in the family (who? ____________________)

☐ Inconsistent responses to sound

☐ Does not startle to loud sound

☐ Does not respond to their name

☐ Other ____________________

Birth and Prenatal History

Place of Birth ____________________

Birth weight ________ lbs ________ oz Premature? ☐ Yes ☐ No APGAR Score (if known) ________

Jaundiced? ☐ Yes ☐ No Highest bilirubin #________ Placed under lights? ☐ Yes ☐ No

Were there any complications during pregnancy or birth? ☐ Yes ☐ No

Describe any pre/post natal problems ____________________

Length of pregnancy ________ Length of labor ________ Birth method ________

At birth did the baby have the following: (please check)

Anoxia (blue color)	☐ Yes ☐ No	Respiratory distress	☐ Yes ☐ No	Jaundice (yellow color)	☐ Yes ☐ No
Remain in the hospital	☐ Yes ☐ No	Swallowing problems	☐ Yes ☐ No	Sucking problems	☐ Yes ☐ No

Mark H. Scoones, Au. D., FAAA
Doctor of Audiology

Turn Over

303 West First Street, Aberdeen, WA 98520 • Phone 360.533.0633 • Fax 360.533.2541
Willapa Harbor Hospital, 800 Alder Street, South Bend, WA 98586 • Phone 360.208.2373 • Fax 360.533.2541
www.westcoasthearing.com

Is your child adopted? ☐ Yes ☐ No If yes, from where? ______________________________

Does your child know he/she is adopted? ☐ Yes ☐ No

Do you have a pre-or post natal report or history of the parents? ☐ Yes ☐ No

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

Who? ______________________________

When? ______________________________

Has your child ever had?

☐ Ear infections? How often? ______________________________

☐ Drainage from one or both ears?

☐ Too much wax in the ears?

☐ Ear tubes placed in the eardrums by an ENT physician?

Name of Physician ______________________________

Where? ______________________________

At what age(s) did treatment occur? ______________________________

Has your child been evaluated by the Early Intervention Program? ☐ Yes ☐ No

Was he/she eligible for their services? ☐ Yes ☐ No

Speech & Language

What concerns do you have about your child's speech? ______________________________

____

____

Has your child been evaluated by any another medical specialist? ☐ YES ☐ NO Check all that apply:

☐ Pediatric neurologist ☐ Developmental specialist ☐ Chiropractor

☐ Physical therapist ☐ Occupational specialist ☐ Audiologist (elsewhere)

☐ Speech-language Pathologist ☐ Early Intervention Program ☐ Other ______________________________

Medical History

Is there any medical diagnosis? (e.g., Down syndrome, cerebral palsy, etc.) ☐ YES ☐ NO

Be specific ______________________________

Family History

Is there a family history of hearing loss? ☐ YES ☐ NO

Who ______________________________

What was the cause (if known) ______________________________

____