WEST COAST HEARING CLINIC
You should HEAR what you're missing!

Child History Questionnaire (2 Years to 17 Years)

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: _____
Are you concerned about your child's hearing? ☐ YES ☐ NO If yes, explain: _____

_____

Does your child have a hearing impairment? ☐ YES ☐ NO ☐ UNKNOWN
Have you ever questioned your child's ability to hear normally? ☐ YES ☐ NO
If yes, please describe: _____
How long have you noticed this problem? _____
Is your child adopted? ☐ YES ☐ NO
If YES, from where? _____
Does your child know he/she is adopted? ☐ YES ☐ NO

Birth and Prenatal History

Birth weight: _____ lbs _____ oz Premature? ☐ YES ☐ NO
Were there any complications during pregnancy or birth? ☐ YES ☐ NO
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	Stay in the hospital	☐ YES ☐ NO
Swallowing problems	☐ YES ☐ NO	Sucking problems	☐ YES ☐ NO

Developmental Milestones

At what age did your child do the following? Sit alone _____ Crawl _____ Walk _____
Do you have any concerns with your child's development? ☐ YES ☐ NO
If yes, explain: _____

Hearing History

Did your child pass their newborn hearing screening? ☐ YES ☐ NO
Has your child recently failed a hearing screening? ☐ YES ☐ NO
Has your child's hearing been tested since birth? ☐ YES ☐ NO
By whom? _____
When? _____
Where? _____

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Does your child have hearing difficulty with: (Check all that apply)

☐ One-on-one conversations ☐ Group of people or multiple talkers ☐ Women voices
☐ Telephone conversations ☐ Children's voices ☐ TV volume
☐ Small group conversations ☐ Presence of background noise ☐ Large group conversations
☐ Other _____

Check all that apply:

Inconsistent responses to sounds? ☐ YES ☐ NO
Look when his/her name is called? ☐ YES ☐ NO
Can hear but has problems understanding ☐ YES ☐ NO
Turn toward loud sounds? ☐ YES ☐ NO
Enjoy listening to music? ☐ YES ☐ NO
Certain loud sounds make child uncomfortable? ☐ YES ☐ NO
The child needs to hear instructions several times ☐ YES ☐ NO
The child "tunes in and out" of listening situations ☐ YES ☐ NO
My child's teacher has mentioned my child having trouble hearing in school ☐ YES ☐ NO

Does your child experience tinnitus (ringing or buzzing) in your ears? ☐ YES ☐ NO

If YES, please answer the questions below:

a) In which ear(s) do they experience tinnitus? ☐ RIGHT ☐ LEFT ☐ BOTH
b) How long have they experienced tinnitus? _____
c) Is it high or low pitched? _____
d) Is it a single noise or multiple sounds? _____
e) Is it a pulsation or rhythmic quality? _____
f) Is it constant or intermittent? _____
g) If intermittent, how often and how long does it last? _____
h) Do they notice tinnitus in quiet situations? ☐ YES ☐ NO
i) Do you notice tinnitus in noisy situations? ☐ YES ☐ NO

Child's Name _____

Has your child had recurrent middle ear infections? ☐ YES ☐ NO
Has your child had medical or surgical treatment for their ears such as PE tubes? ☐ YES ☐ NO
Name of physician _____
Name of clinic _____
At what age(s) did treatment occur? _____
Does he/she ever complain of pain or fullness in the ear? ☐ YES ☐ NO
Has he/she ever been exposed to loud noises or an explosion? ☐ YES ☐ NO
Does your child fall or lose balance easily? ☐ YES ☐ NO
Describe: _____
Does your child use hearing devices? ☐ YES ☐ NO
If so, what type? _____
Does your child use cochlear implants? ☐ YES ☐ NO
Name of physician _____
Name of clinic _____
When did treatment occur? _____
Does your child use BAHA? ☐ YES ☐ NO
Name of physician _____
Name of clinic _____
When did treatment occur? _____

Health History

Check all that apply:

☐ Excessive earwax	☐ Dizziness	☐ Articulation speech disorder	☐ Frequent colds
☐ Vertigo	☐ Language speech disorder	☐ High fevers	☐ Measles
☐ Learning disabilities	☐ Draining ears	☐ Mumps	☐ Attention deficit disorder
☐ Ear infections	☐ Chickenpox	☐ Autism	☐ Tonsillitis
☐ Scarlet fever	☐ Asperger's syndrome	☐ Sinusitis	☐ Meningitis
☐ Cerebral palsy	☐ Mastoiditis	☐ Seizures	☐ Encephalitis
☐ Allergies	☐ Skull fracture	☐ Migraine headaches	☐ Impaired vision
☐ Concussion	☐ Other _____		

Does your child have any open sores, bleeding or drainage at this time? ☐ YES ☐ NO

Describe: _____

Any other serious illnesses? ☐ YES ☐ NO _____

Any other serious surgeries? ☐ YES ☐ NO _____

Is he/she currently (or recently) under a physician's care? ☐ YES ☐ NO

Has your child been evaluated by any another medical specialist? ☐ YES ☐ NO

Check all that apply:

☐ Pediatric neurologist ☐ Developmental specialist ☐ Chiropractor ☐ Physical therapist

☐ Occupational therapist ☐ Audiologist (elsewhere) ☐ Speech-language pathologist

☐ Early intervention program

Speech and Language Development

Which languages are spoken at home? _____

Primary language _____

Are you concerned about your child's speech and language development? ☐ YES ☐ NO

If yes, explain: _____

At what age did your child do the following? Babble _____ Imitate sounds _____ Say first word _____

Use two to three word phrases _____ Make complete sentences _____

About how many words are in your child's vocabulary? _____

Can you understand your child's speech? ☐ YES ☐ NO

Can other people understand your child's speech? ☐ YES ☐ NO

Does your child understand what you are saying? ☐ YES ☐ NO

Does your child follow commands and directions? ☐ YES ☐ NO

How does your child communicate with you? _____

Do you have any additional concerns or questions about your child's hearing communication skills or overall development? _____

_____

School Progress

Is your child in school? ☐ YES ☐ NO

Name of school: _____ Grade: _____

Teacher's name: _____

How would you describe your child's academic performance? _____

_____

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Medication Documentation

Patient Name: _____ Date: _____

Due to new insurance guidelines for audiologists, it is mandatory that we document current medications prior to billing for your services.

If you have a pre-printed list of your medications, completion of this form is not necessary. Please give that list to the receptionist to copy.

Otherwise, please fill out this form and bring it with you to your appointment.

Below, please list each medication you are currently taking and include the following: prescriptions, over-the-counter, herbals and vitamin/mineral/dietary supplements. Thank you!

Medication Name	Dosage	Frequency	Route: Oral, Shots, Dermal, etc.	Dizziness/ Vertigo (office use only)	Hearing Loss (office use only)	Tinnitus (office use only)

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