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PEDIATRIC MEDICAL HISTORY

Patient's Name: ______________________ Today's Date: ______________________

Pediatrician: ______________________ Referring Doctor: ______________________

Pediatrician Address: ______________________ Referring Doctor Address: ______________________

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Phone Number: ______________________ Phone Number: ______________________

Birth Hospital: ______________________

BIRTH HISTORY

1. What is the reason for today's visit? ______________________
2. Did the child's mother experience any complications/illnesses during pregnancy? ❑Yes ❑No
   a. If yes, please describe: ______________________

   ____
3. Length of Pregnancy__________Length of Labor__________Childs Birth Weight__________
4. Was the child in the NICU (Neonatal Intensive Care Unit)? ❑Yes ❑No
   a. If yes, how long was the child in the NICU? ______________________
5. Did your child receive oxygen? ❑Yes ❑No
   a. If yes, for how long? ______________________
6. Did your child receive any known medications/treatments while in the NICU? ❑Yes ❑No
   a. If yes, please list: ______________________
7. Please check an y conditions that were present at the time of your child's birth:

   ❑Jaundice ❑Toxoplasmosis ❑Seizures ❑Cytomegalovirus (CMV)
   ❑Breathing Problems ❑Herpes Simplex ❑Rubella
   ❑Blood Exchange ❑Hyperbilirubinemia ❑Syphilis
   ❑Other: ______________________

8. Please check if your child has experienced any of the following illnesses or conditions:

   ❑Allergies ❑Asthma ❑Colds ❑Tonsillitis
   ❑Headaches ❑Dizziness ❑Tinnitus ❑Sinusitis
   ❑Pneumonia ❑Convulsions ❑Croup ❑Chicken Pox
   ❑Encephalitis ❑Measles ❑Mumps ❑German Measles
   ❑High Fevers ❑Ear Infections ❑Draining Ears ❑Mastoiditis
   ❑Influenza ❑Meningitis ❑Head Injury
   ❑Other: ______________________

MORE ON BACK

MEDICAL HISTORY

1. Has your child been diagnosed with a syndrome? Yes No
    a. If so, please describe: ______________________________
2. Has your child been hospitalized? Yes No
    a. If so, please describe: ______________________________
3. Is your child currently on medication? Yes No
    a. If so, please describe: ______________________________
4. Is there a family history of hearing loss? Yes No
    a. If so, please describe: ______________________________
5. Does your child have a vision impairment? Yes No
    a. If so, please describe: ______________________________
6. Did your child pass their newborn hearing screening at birth? Yes No
    a. If no, was follow-up testing pursued? Yes No
7. Has your child ever received a hearing test? Yes No
    a. If yes, where and what results were obtained? ______________________________
8. Has your child ever had ear surgery? Yes No
    a. If yes, where and what results were obtained? ______________________________
9. H as your child ever received a speech/language evaluation? Yes No
    a. If yes, where and what results were obtained? ______________________________
10. Do you suspect that your child has a hearing loss? Yes No
11. Are you concerned regarding your child's speech production abilities? Yes No

SCHOOL INFORMATION

School Name: ______________________________ Grade: ______________

Does your child receive any special services? ______________________________

Does your child currently have an IEP (Individualized Education Plan)? Yes No

If yes, please describe: ______________________________