

10. Does your child wear hearing aid(s)? _____
 If yes, when was your child first fit? _____
11. Does your child use an auditory trainer? _____
12. Does your child receive preferential classroom seating? _____

Pregnancy And Birth History

- | | Yes | No |
|---|------------|-----------|
| 1. Was the pregnancy abnormal in any way? | _____ | _____ |
| 2. Was the delivery abnormal in any way? | _____ | _____ |
| 3. Was the delivery premature? | _____ | _____ |
| 4. Did the mother have any illness during the pregnancy? | _____ | _____ |
| 5. Did the mother take any medication during the pregnancy? | _____ | _____ |
| 6. After birth, did your child have: | | |
| Breathing difficulties? | _____ | _____ |
| Require an incubator? | _____ | _____ |
| Any head, neck or ear abnormalities? | _____ | _____ |
| Feeding problems? | _____ | _____ |
| Surgery? | _____ | _____ |
| Any infections requiring medication? | _____ | _____ |
| Treatment for jaundice (yellow coloration of the skin)? | _____ | _____ |

If yes to any of the above, briefly explain: _____

Medical History

1. Do you have any medical concerns about your child? _____ Yes _____ No
 If yes, briefly explain: _____

2. Please check if your child has had any of the following:
- | | | | | | |
|--|-------|-------------|-------|-----------------|-------|
| Ear infections | _____ | Meningitis | _____ | Seizures | _____ |
| Ear surgery | _____ | Measles | _____ | Kidney problems | _____ |
| Hospitalization | _____ | Mumps | _____ | Vision problems | _____ |
| Head trauma/injury | _____ | Chicken pox | _____ | Allergies | _____ |
| Noise exposure (e.g. farm equipment, loud music) | _____ | Asthma | _____ | | _____ |

Briefly explain any you checked: _____

 Other significant medical concerns: _____

3. Please list any prescription or over-the-counter medications your child is taking and for what reason(s): _____

Physical Development History

1. Do you have any concerns about your child's physical development? yes no
If yes, briefly explain: _____

2. About what age did your child: hold his/her head erect _____
sit unsupported _____ walk alone _____
3. At what age was toilet training completed? _____
4. Does he/she lose their balance or fall easily? yes no
5. Does he/she seem uncoordinated or clumsy? yes no

Speech and Language History

1. Do you have any concerns about your child's speech and language? yes no
If yes, briefly explain: _____

2. About what age did your child: follow simple directions _____
say his/her first word _____ put two words together _____
3. Did your child continue adding words after the first word? yes no
4. If your child is 2 years old or younger, how many words does he/she use? _____
5. Does your child often use gestures when communicating? yes no
6. Is your child's speech understood by:
parents yes no siblings yes no other adults yes no
7. Has your child's speech ever been evaluated? yes no
If yes, please list by whom, when and results: _____
8. Is your child currently receiving speech therapy? yes no

Additional History

1. Do you have any other concerns about your child? yes no
If yes, briefly explain: _____

2. Does your child:
play/interact well with other children? yes no
have attention/concentration difficulties? yes no
receive any special education services? yes no
If yes to any of the above, briefly explain: _____

3. Do you feel that your child is having any difficulty in school? ___ yes ___ no

If yes, briefly explain: _____

Signature of person completing form

Date

Relationship to patient

7/98