

San Diego State University
Audiology Clinic
5550 Campanile Drive
(619) 594-7747

Pediatric Hearing Information Form

Date of Application: _____

Child's Name: _____ Date of Birth: _____

Parent / Guardian's name(s) _____

Address: _____ Phone: _____
(number, street) (city) (zip code)

Work Phone: _____ Cell Phone: _____ Email: _____

Is the above applicant a Medicare recipient? Yes No

Referring Physician: _____

Physician's Address: _____

Reason for today's visit: _____

Birth History

Length of pregnancy: _____ Child's birth weight _____

Did the child leave the hospital with the mother? Yes / No. If No, please explain: _____

Please check any of the following conditions which were present at the time of the child's birth:

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Cytomegalovirus (CMV) |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Head/Neck Defects |

Medical History

Please provide the approximate ages at which your child experienced any of the following:

Ear surgery / pressure equalization (PE) tubes: _____	Allergies: _____	
Ear infections: _____	Colds / Flu: _____	Dizziness: _____
Tinnitus: _____	Measles: _____	Mumps: _____
High fevers: _____	Meningitis: _____	Head injury: _____
Seizures: _____	Other: _____	

Has your child been diagnosed with a syndrome? Yes / No. If yes, please explain: _____

Has your child ever been hospitalized? Yes / No. If yes, please explain: _____

Please list the names of any medications your child is taking: _____

Hearing History

Do you suspect your child has a hearing loss? Yes / No.

If yes, how long have you noticed a problem? _____

Briefly describe: _____

Does anyone in the family have a hearing loss? Yes / No. If yes, who? _____

Has your child ever had a hearing test? Yes / No. If yes, when and where? _____

Are you concerned about your child's speech and language development? Yes / No

Briefly describe: _____

Other Information

Please check any of the following evaluations your child has received:

Developmental

Educational

Psychological

Speech and Language

Other: _____

Does your child attend daycare or school? Yes / No. Grade: _____

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

Name of school: _____ City _____

In the space below, please provide any other information you feel we should know: _____
