HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

Audiology Child History Form

Child's Name: _____ Date of Birth: _____

Person completing this form/Relationship: _____

I. **Describe your major concern(s) about your child**: _____

_____

_____

_____

II. **What specific questions would you like to have answered**: _____

_____

_____

_____

III. **Prenatal and Birth History:**

1. During this pregnancy, did the mother experience any unusual illness, accident or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please describe: _____

_____

_____

2. During the pregnancy did the mother (*please check)*
   - ☐ Take medication? ☐ Smoke?
   - ☐ Drink alcohol? ☐ Take recreational drugs?

   Please describe: _____

   _____

3. Were there any complications with delivery? ☐ Yes ☐ No

   Please describe: _____

   _____

4. Birth weight:_____ How many weeks gestation at time of delivery: _____

5. Condition of baby at birth: _____

   Jaundiced? ☐ Yes ☐ No If yes, how was it treated? _____

6. Any time spent in the neonatal intensive care unit (NICU)? ☐ Yes ☐ No

   Length of stay: _____

   Reason: _____

   _____

   _____

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IV. Medical History

1. Is the child in good health at this time? _____
2. Other medical conditions or diagnoses? _____
   _____
3. Does the child have a suspected or known hearing loss? ☐ Yes ☐ No
4. Does anyone in the child's biological family have a hearing loss? ☐ Yes ☐ No
   Please list: _____
5. Does/did your child suffer from any of the following? *(please check)*
   ☐ Frequent colds ☐ Seasonal allergies
   ☐ Ear infections ☐ History of fevers
   When was the most recent? _____ How was it treated?: _____
6. Has your child had a hearing test before? ☐ Yes ☐ No
   If yes, where? _____ When? _____
   What were the results? _____
7. Does your child wear hearing aids? ☐ Yes ☐ No If yes, how long? _____
8. Has your child seen a physician for an ear examination? ☐ Yes ☐ No
   When? _____ Results: _____
   Physician: _____ Clinic/Hospital _____
9. When was your child's most recent physical examination? _____
   Physician: _____ Clinic/Hospital _____

V. School History

1. Is your child now in school, preschool, and/or day care? ☐ Yes ☐ No
2. Name of the current school: _____
3. Hours and days of attendance per week: _____

VI. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

_____
_____
_____

VII. Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Email: _____