HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Birth/Medical History

Patient's Name: _____ Today's Date: _____

Pediatrician: _____ Referring Doctor: _____

Pediatrician Address: _____ Ref. Doctor Address: _____

_____ _____

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 know mediations/treatments while in the NICU? [ ] Yes [ ] No
   a. If yes, please list: _____
7. Please check any conditions that were present at the time of your child's birth:

[ ] Jaundice	[ ] Toxoplasmosis	[ ] Seizures	[ ] Cytomeglavirus (CMV)
[ ] Breathing Problems	[ ] Herpes Simplex	[ ] Rubella	
[ ] Blood Exchange	[ ] Hyperbilirubinemia	[ ] Siphilis	
[ ] 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:_____			

Laurel
14201 Laurel Park Drive, 109
Laurel, MD 20707
301-604-3177

Bowie
4000 Mitchellville Road, B124
Bowie, MD 20716
301-464-2036

Waldorf
3460 Old Washington Rd, 203
Waldorf, MD 20602
301-932-4237

California
23077 Three Notch Road, 101
California, MD 20619
301-737-4040

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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. Has 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:_____

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