Child/Adolescent History Form

Name:_____ Date:_____ Age:_____

Has your child ever failed a hearing screening? Yes No

Do you feel your child has difficulty hearing? If yes, explain_____ Yes No

_____

Is your child having difficulty at school? If yes, explain_____ Yes No

_____

Does your child receive extra help at school? If yes, explain _____ Yes No

_____

Does your child use an assistive listening device at school? Yes No

Does your child use hearing aids? If yes, circle one: Left Right Both Yes No

Is there a history of ear infections? Yes No

Has your child ever had PE tubes? Yes No

Has your child ever had surgery on ear, nose or throat? If so, explain_____ Yes No

_____

Is there any family history of hearing loss? If yes, explain_____ Yes No

Is your child currently on any medication? If yes, explain_____ Yes No

---

Audiologist's Notes:_____

_____

_____

_____