Alexandria Hearing Center

Massa and Associates

Pediatric Patient History

Patient Name: _____ Date of Birth: _____

Parent(s) Name: _____

Pregnancy History:

Did Mother have normal Pregnancy? Yes No, please explain

_____

_____

Birth History:

1.) Was it a normal delivery? Yes No, please explain
2.) Was baby full term? Yes No, weeks of gestation _____
3.) Name of Birth Hospital _____
City, State of Hospital _____
4.) Was your child in the NICU? No Yes (See Below)

a.) Why was your child in the NICU? _____
b.) How long were they in the NICU? _____
c.) Do you know what medicine they were on in the NICU? _____

Initial Screening:

Did your child pass their hearing test at the hospital? N/A Yes No, failed (Left/Right)

Do you know which test was performed at the hospital? ABR OAE

Family History:

Is there history of hearing loss in the family? No Yes, please explain

Audiologist Signature: _____ Date: _____