



Child's Name: _____ Birthday _____
 Physician: _____
 Ear Specialist: _____ Phone # _____
 Parent/Guardian: _____ Date: _____

	NO	YES	(if yes, please explain)
Does your child have any medical concerns?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Is there a family history of ear/hearing problems?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Were there problems during pregnancy/delivery?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Did your child fail the hearing screen at birth?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there concerns about overall development?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child been hospitalized?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child had Meningitis?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child had a head injury?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Does your child have allergies?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there allergies in the family?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there concerns about your child's hearing?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there concerns in how your child responds to:			
Their name?	<input type="radio"/> No	<input type="radio"/> Yes	_____
The T.V.?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Conversations?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Listening in noise?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there concerns about your child's speech?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Does your child have frequent/severe colds?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child had ear infections or fluid build up?	<input type="radio"/> No	<input type="radio"/> Yes	_____
If so, approximately how many times?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child had surgery for ear problems?	<input type="radio"/> No	<input type="radio"/> Yes	_____
If so, what was done and when?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Has your child had their tonsils/adenoids removed?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Is your child on an IEP at school?	<input type="radio"/> No	<input type="radio"/> Yes	_____
If so, who is the case manager?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Are there any concerns in school?	<input type="radio"/> No	<input type="radio"/> Yes	_____

AUDIOLOGIST'S NOTES

MEDICAL:
 Medication _____

 Surgery _____

 Other _____

EDUCATIONAL:
 Academics _____

 Classroom Concerns _____

 Other _____

AMPLIFICATION:

OTHER:

