Educational Audiology Health History

Date: _____

General History

Student's Name: _____ Date of Birth: _____ Age: _____

Person completing form: _____ Relationship to student: _____

Mother's Name: _____ Father's Name: _____

Student resides with (include siblings):_____

Home Address: _____ Phone: _____

City: _____ State: _____ Zip code: _____ E-mail: _____

Educational Information

Grade: _____ School: _____ Teacher or school contact: _____

School performance (circle): Above average Average Below average

Repeated a grade? ___Yes ___No If so, which grade(s)? _____ Frequent school absences? ___Yes ___No

Please list specific areas of academic difficulty if any: _____

Please list specific areas of academic strength if any: _____

Please list any other learning concerns? _____

Does your son/daughter receive any special education services? If yes, what services & times per week?

_____

Does your son/daughter have any speech-language problems? ____ If yes, please explain: _____

_____

Developmental/Medical/Family History

Complications during pregnancy: _____

Medications/drugs used during pregnancy: _____

Alcohol used during pregnancy (how often): _____

Newborn Hearing Screening: Pass ____ Fail ____ Unknown ____

Is there a family history of Hearing Loss (if yes, who): _____

Does your child have any ear problems? ___infections ___eardrum perforations ___wax ___drainage ___ear pain

Has your Child ever seen an Ear, Nose, and Throat (ENT/Otolaryngologist) specialist? _____

Has your child ever received pressure equalizing (PE) tubes for chronic ear infections? _____

How many sets? _____ At what ages? _____

Does your child have frequent colds, allergies, or congestion? ___Yes ____ No

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Please indicate if your son/daughter has experienced any of the following:

___ Premature birth
___ Problems before, during, or after birth
___ Hyperbilirubinemia/jaundice
___ Bacterial meningitis
___ Congenital or perinatal infections
___ Asphyxia/lack of oxygen at birth
___ Mechanical ventilation
___ Head or neck abnormalities
___ Fetal alcohol syndrome
___ Fever over 104 degrees
___ Currently takes medication
___ Known hearing problems
___ Speech-language difficulties
___ Sensory integration issues
___ Autism spectrum disorder
___ Attention deficit hyperactivity disorder
___ Syndromal abnormality
___ Serious illness or accidents
___ Delays in development

If your child has experienced any of the above, please explain (include specific treatment and medications: _____
_____
_____

Behaviors and Characteristics

Please indicate if your son/daughter exhibits any of the following:

___ Sensitive to loud sounds
___ Appears to be confused in noisy places
___ Easily upset by new situations
___ Difficulty following directions
___ Restless/problems sitting still
___ Short attention span
___ Impulsive
___ Easily distracted
___ Daydreams
___ Forgetful
___ Asks for repetition
___ Reverses words, numbers, or letters
___ Difficulty learning new concepts
___ Difficulty with reading
___ Difficulty understanding the meaning of words alone
___ Disruptive or rowdy
___ Temper tantrums
___ Shy
___ Anxious
___ Lacks self confidence
___ Lacks motivation
___ Uncooperative
___ Disobedient
___ Inappropriate social behavior
___ Easily frustrated
___ Tires easily
___ Prefers to play
___ Seeks attention
___ Difficulty expressing idea

Is there any additional information that is important for the audiologist to know? _____
_____
_____

Printed name of Person Providing Information: _____

Signature of Person Providing Information: _____

Date: _____

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