Syracuse Hearing Solutions
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Confidential Patient Audiologic History - Child (<18 years of age)

Patient Name: _____ Date of Birth: _____Today's Date:_____

Do you feel your child has trouble hearing? Describe concern _____

Birth or pregnancy complications? YES NO If yes, please explain _____

Passed newborn hearing screening? YES NO

Language development – Any developmental delays? YES NO If yes, please explain _____

Developmental milestones met at appropriate ages? YES NO

Hx of ear infections? YES NO HOW MANY? _____ When was child's last ear infection? _____

PE tubes? YES NO If yes, when were the tubes placed? _____

Family history of hearing loss? YES NO WHO? _____

Other medical hx (other diagnoses?) _____

Academic performance (if applicable)
-Describe academic performance. _____
-Any areas of difficulty? _____

Does your child receive any support services? (SLP, PT, OT, Special education)
Please check all that apply. If checked, please explain

____ Tinnitus (sounds in the ear)? If checked, RIGHT LEFT BOTH EARS

_____ Ear Drainage? If checked, RIGHT LEFT BOTH EARS When did it start?_____

_____ Ear Wax Buildup? If checked, RIGHT LEFT BOTH EARS When did it start?_____

_____ Family History of Hearing loss If checked, who? _____

_____History of Noise Exposure? If checked, please describe _____

_____ History of ear trauma? YES NO If yes, please describe_____

___History of head trauma? YES NO If yes, please describe_____