Pediatric Medical History

Patient Name: ______________________________ DOB: __________________

What is your primary reason for today's visit? __________________________

Are you concerned about your child's hearing? _________________________
Why? ____

Pregnancy and Delivery

Full term? ______wks
Gestational diabetes? ______
Illness? ______
C-section? ______
Complications? ______
Apgar score? ______

Birth history

Birth weight? ______
Jaundice? ______
Medication? ______
Lack of oxygen? ______
Blood transfusion? ______
Syndrome? ______

Medical History

High fevers? _________________________
Seizures? ____________________________
Hospitalizations? ____________________________________
Surgeries? (include tubes) __________________________
Present medications? ________________________________
Family history of hearing loss? _______________________
History of ear infections? _________________ How many? ______________

Social History

Does your child interact well with others his/her own age? ______________
Behavior problems?
____
School grade? __________ Name of school? ___________________________

____ _______________________
Parent or Legal Guardian Date