Ashley Engle, Au.D.
Audiology & Hearing Aid Services, LLC.

Patient History - Please answer the following questions. Some questions may not apply to your child, so please mark them not applicable (n/a). Please bring the answered questionnaire to your child's appointment.

1. Were there any complications during the pregnancy or birth? If yes, please explain.

_____

_____

2. Was your child a low-birth weight? _____

3. Was your child premature? _____ If yes; how many weeks? _____

4. Was your child on any medications at birth? If yes, please list.

_____ _____ _____ _____

_____ _____ _____ _____

5. Was your child on a ventilator at birth? _____ If yes, how long? _____

6. Did your child have jaundice? _____

7. Did your child have a blood transfusion? _____

8. Was the mother treated for any infections during the pregnancy? _____ If yes, please list.

_____

9. Did your child pass the newborn hearing screening at birth? _____
   If no, which ear did not pass? **right** **left** **both**

10. Has your child had a hearing evaluation before? _____ If yes, when? _____

11. Has your child had any ear infections? _____
    If yes, when was the last ear infection? _____ How was it treated? _____

12. Has your child had tubes in his or her ears? _____ If yes, are they still in place?_____

13. Has your child complained of ear pain or tugged at his or her ears recently? _____

14. Has there been any recent drainage from your child's ears? _____

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15. Has your child had any ear surgeries? _____ If yes, when:_____

16. Has your child experienced any trauma to the head/neck area? _____ If yes, please explain:

_____

_____

17. Is there a family history of hearing loss? _____ If yes, please list family members. (Example: Grandfather, sister, etc.) Did any of these family members have hearing loss at birth or a young age?

relation: _____ age: _____ relation: _____ age: _____

relation: _____ age: _____ relation: _____ age: _____

18. How is your child's speech development?

_____

_____

19. Is your child's speech understandable to others?	**yes**	**no**
20. Has your child had a speech and language evaluation?	**yes**	**no**
21. Is your child in speech or language therapy?	**yes**	**no**
22. Does your child startle to loud sounds?	**yes**	**no**
23. Does your child turn or respond to familiar voices/sounds?	**yes**	**no**
24. Does your child respond to his or her name?	**yes**	**no**

25. Has your child's development such as sitting up, first words, and walking been delayed?

_____

Please list any other important information.

_____

_____

_____

_____

_____

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_____

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