



HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Birth/Medical History

Patient's Name: _____ Today's Date: _____
 Pediatrician: _____ Referring Doctor: _____
 Pediatrician Address: _____ Ref. Doctor Address: _____

 Phone Number: _____ Phone Number: _____
 Birth Hospital: _____

Birth History

1. What is the reason for today's visit?
2. Did the child's mother experience any complications/illnesses during pregnancy? Yes No
 - a. If yes, please describe : _____

3. Length of Pregnancy _____ Length of Labor _____ Childs Birth Weight _____
4. Was the child in the NICU (Neonatal Intensive Care Unit)? Yes No
 - a. If yes, how long was the child in the NICU? _____
5. Did the child receive oxygen? Yes No
 - a. If yes, for how long? _____
6. Did the child receive any know mediations/treatments while in the NICU? Yes No
 - a. If yes, please list: _____
7. Please check any conditions that were present at the time of the child's birth:

<input type="checkbox"/> Jaundice	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cytomoglavirus (CMV)
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Herpes Simplex	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Blood Exchange	<input type="checkbox"/> Hyperbilirubinemia	<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Other: _____			
8. Please check if the child has experienced any of the following illnesses or conditions:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Colds	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Croup	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> German Measles
<input type="checkbox"/> High Fevers	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Draining Ears	<input type="checkbox"/> Mastoiditis
<input type="checkbox"/> Influenza	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Head Injury	
<input type="checkbox"/> Other: _____			

Laurel
14201 Laurel Park Drive, 109
Laurel, MD 20707
301-604-3177

Bowie
4000 Mitchellville Road, B124
Bowie, MD 20716
301-464-2036

Waldorf
3460 Old Washington Rd, 203
Waldorf, MD 20602
301-932-4237

California
23077 Three Notch Road, 101
California, MD 20619
301-737-4040



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Medical History

1. Has the child been diagnosed with a syndrome? [] Yes [] No
a. If so, please describe: _____
2. Has the child been hospitalized? [] Yes [] No
a. If so, please describe: _____
3. Is the child currently on medication? [] Yes [] No
a. If so, please describe: _____
4. Is there a family history of hearing loss? [] Yes [] No
a. If so, please describe: _____
5. Does the child have a vision impairment? [] Yes [] No
a. If so, please describe: _____
6. Did the child pass their newborn hearing screening at birth? [] Yes [] No
a. If no, was follow-up testing pursued? [] Yes [] No
7. Has the child ever received a hearing test? [] Yes [] No
a. If yes, where and what results were obtained? _____
8. Has the child ever had ear surgery? [] Yes [] No
a. If yes, where and what results were obtained? _____
9. Has the child ever received a speech/language evaluation? [] Yes [] No
a. If yes, where and what results were obtained? _____
10. Do you suspect that the child has a hearing loss? [] Yes [] No
11. Are you concerned regarding the child's speech production abilities? [] Yes [] No

School Information

School Name: _____ Grade: _____

Does the child receive any special services? _____

Does the child currently have an IEP (Individualized Education Plan)? [] Yes [] No

If yes, please describe: _____

Parent Information:

Parent/Parents Name(s): _____

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