



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



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

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

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:

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

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: _____

