

CHILD HISTORY FORM
(Audiologic Evaluation)

CHILD'S NAME _____ BIRTH DATE ___/___/___

PARENTS/GUARDIAN'S NAME _____

SCHOOL _____ GRADE _____

OTHER CHILDREN IN FAMILY

NAME	AGE	SEX	SCHOOL	GRADE REACHED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HEALTH OF MOTHER DURING PREGNANCY

1) Any unusual illness? (Measles, RH Blood Factor, Etc.) Yes ____ No ____

If YES – explain _____

2) Pregnancy ____ mos. Labor ____ hours Birth weight ____ lbs. ____ oz.

Circle any of the following which apply:

- | | | | |
|--------------|------------------------|--------------------------|-------------------|
| Breech Birth | Instruments Used | Caesarean Section | Trouble Breathing |
| Dry Birth | Unusual Color at Birth | Unusual Scars or Bruises | Incubator Used |

HEALTH AND DEVELOPMENT OF THE CHILD

- 1) Age sat alone _____ months.
- 2) Age walked alone _____ months.
- 3) Toilet training began at age _____ months. Completed _____ months.
- 4) Child's physical development has been: FAST NORMAL SLOW
- 5) Coordination: GOOD CLUMSY
- 6) Previous hospitalization YES NO
- 7) Difficulty swallowing or choking YES NO
- 8) Eye problems YES NO
- 9) Any serious illnesses YES NO
- 10) History of high fevers YES NO
- 11) History of seizures or convulsions YES NO
- 12) Any serious accidents YES NO
- 13) Any surgical operations YES NO

