Northern Hearing Services, Inc.
Anchorage: 4200 Lake Otis Parkway, Suite 302 | Anchorage, Alaska 99508
(907) 561-1326 | fax. (907) 561-2865
Wasilla: 935 Westpoint Drive, Suite 101 | Wasilla, Alaska 99654
(907) 357-1326 | fax. (907) 357-1396
Statewide: 888-391-1326

Child History Form

Birth to 12 years

PATIENT NAME: _____

PARENT/GUARDIAN: _____

Primary complaint: _____

1) Where was your child born (city/state)? _____
2) Name of birth hospital: _____
3) Was your child full term (36-40 weeks) or premature (<36 weeks)? _____
   If premature, how many weeks? _____
4) Were there any complications at birth? (circle one) Yes No
   If yes, please explain: _____
5) Was your child hospitalized after birth? Yes No
   If yes, why and for how long? _____
6) Was your child's hearing screened at birth? Yes No Don't Know
   If yes, what were the results: PASS REFERRAL
7) How many ear infections did your child have prior to the age of one? _____
8) How many ear infections to date? _____
9) Has your child had ear problems in the last six months? Yes No
10) Has your child been evaluated by an ear specialist (ENT)? Yes No
    If yes, who did they see and when? _____
11) Has your child had tubes? Yes No
    If yes, how many times? _____
12) Is there a family history of hearing loss? Yes No
    If yes, please explain: _____
13) Does your child have frequent colds, problems with sinuses and/or allergies?
    Yes No If yes, please explain: _____
14) List any medications your child is taking: _____

_____

Northern Hearing

Child History Form (cont.)

Birth to 12 years

15) How does your child communicate? (ex. Pointing, gestures, words, sentences, etc.)

_____

16) Do you have any concerns about speech and language development? Yes No N/A
If yes, please explain: _____

17) Does your child attend day care, preschool or public/private school? Yes No
If yes, where? _____ How often? _____

18) Do the teachers or caregivers have concerns? Yes No

19) How does your child do in school? _____

20) Do you think your child has difficulty hearing? Yes No Sometimes
If yes, please explain: _____

21) Do you have any concerns about your child's vision? Yes No
If yes, please explain: _____

22) Is your child receiving any kind of services (ex. occupational therapy, physical therapy, speech therapy, etc.)? Yes No
If yes, where? _____
By whom? _____ How often? _____

23) Does your child currently wear hearing aids? Yes No
If yes: Make _____ Model _____
Year Purchased _____ Bought where? _____

24) Has your child been diagnosed with any pre-existing conditions? (circle all that apply)

Down's Syndrome	Cleft Lip/Palate	Autism/PDD
Usher's Syndrome	Waardenburg's Syndrome	Cytomegalovirus (CMV)
Alport's Syndrome	Stickler's Syndrome	Congenital Syphillis
Leukemia	Muscular Dystrophy	ADD/ADHD
Fetal Alcohol Syndrome	Sickle Cell Anemia	Cerebral Palsy (CP)
None	Other: _____	

25) Is there any other information we should know? _____

_____

Signature _____ **Date** _____

(Please note: All information is completely confidential and available only per release of the patient)