Hackensack Meridian *Health*
Mountainside Medical Center

Audiology Department History Form-Child

Date: _____

Person completing this form: _____ **Relationship to child:** _____

Child's name: _____ **Referred by:** _____

Address: _____ **Pediatrician:** _____

_____ **School Attending:** _____

Grade:_____

Child's birthdate:_____ **Age:**_____

Parent's home phone: _____
Parent's cell phone: _____ **Hospital of birth:** _____

Why was a hearing test requested? _____
_____

Has your child had any of the following:

Earaches/ear infections	yes	no	tonsillitis	yes	no
Chronic colds	yes	no	ear tubes	yes	no
Allergies	yes	no	speech delay	yes	no
Running ears	yes	no	learning problems	yes	no
Fluid in the ears	yes	no	head injuries	yes	no

Is your child taking any medications? Please list: _____
_____

Describe any surgeries or hospital stays your child has had

When: _____

Where done: _____

Procedure performed: _____

Doctor's name: _____

Is there a family history of hearing problems? Please describe_____
_____

*** Please bring this completed form to your hearing test appointment.**