Ear, Nose, and Throat Consultants, Inc.

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Pediatric Audio History

Patient's Name:_____
Date: ___/___/____
DOB: ___/___/____
Referring Provider: _____

	YES	NO	
Speech/Language Concerns:	O	O	_____
Hearing Concerns:	O	O	_____
Healthy Pregnancy:	O	O	_____
Healthy Birth:	O	O	_____
History of Prematurity	O	O	_____
Recurrent Ear Infections:	O	O	_____
History of Ear Infection:	O	O	_____
Feeling of Ear Fullness:	O	O	_____
Family history of Dizziness:	O	O	_____
Previous head injuries:	O	O	_____
CT scan of ears/head?	O	O	Date: _____
MRI of ear/head?	O	O	Date: _____
Did you have any previous hearing tests done?	O	O	Date:_____
Do you have any ear disorders?	O	O	

	YES	NO	
History of Ear Surgery:	O	O	_____
Date:			_____
Type:			_____
Family history of hearing loss:	O	O	_____
Mothers Side:			_____
Fathers Side:			_____

Mothers Side: _____
Fathers Side: _____

OTHER:
_____
_____
_____