HUNTER COLLEGE CENTER FOR COMMUNICATION DISORDERS PEDIATRIC HISTORY FORM IN AUDIOLOGY

Child's Name:		Sex M or F (please circle "qt" ej gem)		(Date)
Date of Birth:	Age:	(picuse enere qi ej gen)		(Bute)
Parent/Guardian (Full Name):				
Mailing Address:				
· · · · · · · · · · · · · · · · · · ·	(Apt)	(City	, State)	(Zip)
Phones:(home)	(Cell)		(Office)	
			(Office)	
E-mail:	(clearly PRINT e-ma	il address)		
Referral				
	(Full name with credentials, e.g., M	IS CCC-SLP, MD, PhD)		
Referral's Address:(if mailing report to him/her) (Street)	(Suite) (City	, State)	(Zip)
What is the chief complaint?				
When was problem first noted?				
Does your child receive any services a	at that time (if yes, please li	st):		
	() /1	,		
School	Prima	ry Language		
DEVELOPMENTAL HISTORY	Рн	YSICAL HISTORY		
Age of first smile?		Cleft lip or palate	Yes	No
Age when sat up alone?		Low-set ears	Yes	No
Age when first crawled?		High fevers with illness	Yes	No No
Age of "stranger anxiety"?		Seizures Poorly formed ears	Yes Yes	No No
Age of walking?		roomy formed ears	1 68	NO
COMMUNICATION HISTORY				
At what age was your child's speech u	ınderstood?			
Does your child show any frustration v	with communication?			
Does your child communicate his/her				
	1 3			
D C 14b . 4 bild C. II Ii				
Do you feel that your child follows dir	rections appropriately?			
Does your child hear environmental so	ounds like the telephone, do	orbell, etc?		
How would you describe your child's	performance at school?			
How would compare this child's devel	lopment to that of his/her si	blings?		
-				
(P	PLEASE TURN OVER AND CO	MPLETE OTHER SIDE)		

osed to:				
	No			
Yes	No		s No	
Yes	No	Hepatitis Yes	No No	
Yes	No	HIV/AIDS Yes	No No	
Yes	No			
Yes	No			
Yes	No			
Yes	No	Did your child receive a		
Yes	No	newborn hearing screening		
		before leaving		
Yes	No	1 3		
_	No			
Yes	No No			
Yes	No	Bilirubin >15 mg/100 ml	Yes	No
1 05	110			No
Ves	No	•		No
Yes	No	7 7	1 63	110
	- 1.0		Yes	— No
Ves	– No			No
Yes	No			
Vac	— No	Complement malays	Vac	No
				No
1 7	— N.	Head trauma	res	No
	No			
		~ 1.1		
				No
		*		No
Yes	No		Yes	No
Yes	No	Sickle cell disease	Yes	No
Yes	No	Other, please specify		
Yes	No			
Yes	No			
· ———				
	Yes	Yes No	Yes No Cytomegalovirus Yes Yes No Toxoplasmosis Yes Yes No Hepatitis Yes Yes No Hepatitis Yes No Hepatitis Yes No Yes No Yes No Yes No Yes No Hill yes No Hill yes No Hepatitis Yes No Hill yes No Hepatitis Yes No Hepatitis Yes No Hepatitis Yes No Hepatitis Yes No Yes No Hepatitis Yes No He	Yes No Cytomegalovirus Yes No Yes No Cytomegalovirus Yes No Yes No Toxoplasmosis Yes No Yes No Hepatitis Yes No Yes No Hepatitis Yes No Yes No HIV/AIDS Yes No Yes No HIV/AIDS Yes No Yes No HIV/AIDS Yes No Yes No Did your child receive a newborn hearing screening before leaving hospital after delivery? Yes No Did your child pass? Yes No