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SAN ANTONIO HEAD & NECK SURGICAL ASSOCIATES, P.A. DBA
Ear, Nose & Throat Clinics of San Antonio, P.A.

Child's Name: ___________________________ ☐ Male ☐ Female Date of Birth: ____________________
School/grade: ____________________________Person Completing Form: _________________________________
Is child receiving speech therapy? _________Where? __________________How often? ______________________
What is the primary language spoken in the home? ____

♦♦

CHILD'S HEALTH HISTORY

Yes No

☐ ☐ 1. Was your child born prematurely? If yes, how many weeks?______________________________

☐ ☐ 2. Was your child admitted to the NICU following birth?
If yes, please explain:
____

☐ ☐ 3. Did your child have any birth injuries or congenital abnormalities?
If yes, please explain:
____

☐ ☐ 4. Were/are there any respiratory problems? If yes, explain:
____

☐ ☐ 5. Has your child ever had seizures? If so, on medication? _________________________________
☐ ☐ 6. Has your child had frequent ear infections?
☐ ☐ 7. Has your child had tubes place in the ears?
☐ ☐ 8. Does your child have normal hearing and vision?
If not, explain:
____

☐ ☐ 9. Were there any delays in speech or language development?
If so, explain:
____

☐ ☐ 10. Were there any delays in fine/gross motor development such as writing , opening clasps, walking, crawling, etc.
If so, explain:
____

☐ ☐ 11. Has your child had any major accidents or illnesses since birth requiring hospitalization or surgery? If so, explain:
____

Yes No

☐ ☐ 12. Has your child been diagnosed with any recurring or on-going illnesses or conditions such as hearing or vision loss, ADD/ADHD, breathing difficulties, autism spectrum disorders, etc?
If so, please explain what the diagnosis was and when it was given:_____

☐ ☐ 13. Has your child had PE tubes inserted? If **yes**, how many times have they been inserted?____
Insertion Date:_____

☐ ☐ 14. Do you have any concerns about your child's eating or swallowing habits?
If so, explain: _____

☐ ☐ 15. Does/did your child suck his/her thumb? If so, when did they stop?

Please provide the following information on health care providers currently serving your child:
May we contact them? ☐ Yes ☐ No

Provider Name	Specialty	Phone

Please provide the following information on any medications your child is currently taking:

Name of Medication	Reason	Length of use	Side effects

Please provide the following information on any educational, developmental, medical, or psychological evaluations your child has had in the last three years. May we contact them? ☐ Yes ☐ No

Type of Evaluation	Evaluator (school, physician, etc)	Date of Evaluation	Do you have a copy?

SOCIAL HISTORY

Please indicate how your child gets along with the following people:

Parents:
Siblings: Names and ages of siblings:

Please explain any significant behavior concerns such as recent changes or problem behaviors:

_____

_____

Please explain any significant changes in the child's environment that we should be aware of:
(ex.: family illnesses, births, deaths, divorce, new school, move to new home, etc.)

_____

_____

EDUCATIONAL HISTORY

Child's School/Day care: _____ May we contact them? ☐ Yes ☐ No
School/Daycare phone number: _____

Has anyone in your family been diagnosed with or had learning difficulties? ☐ Yes ☐ No
If so, please explain:

_____

Please explain any concerns about your child's learning as specifically as possible:

_____

_____

_____

_____

THERAPEUTIC GOALS

Please explain any concerns about your child's speech as specifically as possible:
Speech Therapy:

_____

_____

_____

_____

_____