Lawrence Speech & Hearing Services

Youth Medical History

Patient Name: ____

Birth	Yes	No
Was your child full-term at pregnancy?		
Did your child weigh less than 5 pounds at birth?		
Did your child have breathing problems at birth?		
Did your child have any defects of ear, nose or throat at birth?		
Did your child experience paralysis at birth?		
Did your child have seizures at birth?		
Did your child have feeding problems at or after birth?		

Childhood	Yes	No
Eye or vision problems?		
Balance/gait/dizziness problems?		
Seizures?		
Cerebral palsy?		
Head/skull injury?		
Meningitis?		
Chickenpox?		
Encephalitis?		
Septicemia?		
Measles?		
Diabetes?		
Influenza?		
Sickle Cell?		
Cytomegalovirus (CMV)?		
Rubella?		
Mumps?		
Kidney Problems?		
Allergies		
Asthma?		
Surgeries?		
“Tubes” in ears?		

Please explain any answers marked “yes”: ____

____

Current medications: ____

Person completing form:____

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Relationship to patient: ______________________________

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