AUDIOLOGY EXPERTS

Pediatric Case History Form

To be completed by parent or guardian.

Child's name:

_____

Birth date: _____/_____/_____ **Age:** _____ **Gender:** F M

Pediatrician: _____

Referring physician:

_____

Reason for visit:

_____

HEARING HISTORY:

1) Do you have any concerns about your child's hearing? **Y** **N**
2) Does anyone in your family have hearing loss beginning before age 30? **Y** **N**
3) Does anyone in your family have night blindness? **Y** **N**
4) Does your child have any history of ear infections? **Y** **N**
If yes, what treatment was given? _____
5) Has your child had surgery on his/her ear? **Y** **N**

_____

6) Does your child consistently respond to your voice? **Y** **N**
7) Does your child startle to loud sounds? **Y** **N**
8) Can your child accurately locate where sound is coming from? **Y** **N**
9) Has your child's hearing ever been tested? **Y** **N**
If yes, by whom, when, and results:

_____

10) Does your child wear hearing aids? **Y** **N**
If yes, since what age? _____

PREGNANCY AND BIRTH HISTORY:

Birth weight: _____ Term of pregnancy: _____

Were medications given to the mother during pregnancy? **Y** **N**
Please list any and reason given:

_____

Was the pregnancy or delivery abnormal in any way? **Y** **N**
If yes, please explain:

_____

During pregnancy did the mother:
Smoke **Y N**
Drink alcohol **Y N**
Use drugs **Y N**
At the child's birth:
Was oxygen administered **Y N**
Jaundiced **Y N**
NICU **Y N**
Other difficulties: (If yes, explain) **Y N**

_____

Does your child have any known birth defects or disabilities **Y N**
If yes, please explain:

_____

POST-NATAL HISTORY:
List any medications your child is currently taking and reasons for taking them:

_____

Has your child ever had:
Frequent high fevers **Y N**
Frequent colds **Y N**
Allergy or sinus problems **Y N**

Balance/equilibrium difficulties: (If yes, please explain) **Y N**

_____

Head trauma/accidents (If yes, please explain) **Y N**

_____

Speech/language difficulties or delays: (If yes, please explain) **Y N**

_____

Physical/motor developmental delays: (If yes, please explain) **Y N**

_____

Additional comments or concerns:

_____

Signature of person completing form: _____

Relationship to patient: _____Date:_____