Hearing Solutions

**PEDIATRIC AUDIOLOGY CASE HISTORY**

Child's Name: _____DOB: _____Date: _____Chart#:_____

Person completing form: _____Relationship to patient: _____

Describe the reason for today's visit: _____

Have you ever questioned your child's ability to hear normally? ☐YES ☐NO
If yes, please describe: _____

At what age was your child's problem first noticed? _____By whom: _____

Has your child's hearing been tested? ☐YES ☐NO
If yes, Where? _____ When? _____ Results? _____

Is there a family history of hearing loss? ☐YES ☐NO
If Yes, Who? _____What age was the loss identified? _____

Other children in your family: Age and Gender: _____

## Prenatal and Birth History

Please check and of the conditions that apply to your pregnancy:

| | | |
|---|---|---|
| ___Rh incompatibility | ___Substance abuse | ___Syndromes (i.e. Ushers, Down's) |
| ___Cytomegalovirus (CMV) | ___Lack of oxygen | ___Kidney Infection |
| ___Rubella/German Measles | ___Infections | ___Toxemia |
| ___Communicable Diseases | ___Medication | ___Car accidents/Falls |

Age of mother at birth: _____Length of Pregnancy: _____ Child's Birth Weight: _____Apgar scores: 1 min___5 min___

| | | |
|---|---|---|
| ___Caesarean/Breech | ___Lack of oxygen | ___Special neonatal care or NICU |
| ___Medication given to child | ___Jaundice | ___Medication given to mother |
| ___Congenital defects | ___Syndromes | |

Did your child have a newborn hearing screening? ☐YES ☐NO
___Pass ___Referred: ___Left ___Right ___Both ___Incomplete Name of birth hospital: _____

If you checked any of the above conditions above, please describe: _____

_____

## Child's Hearing History

Age of first ear infection: _____ How many ear infections: Age 0-2 years_____, Age 2-4 years_____, Age 4-6 years

Date of last ear infection: ____ If recent, is your child currently taking medication for this problem? _____

Has your child had medical or surgical treatment for their ears, such as tubes? _____

At what ages? _____Does your child currently have tubes? _____ENT Physician: _____

Has your child ever described noise or ringing in the ear? ☐ YES ☐NO
Which ear? ___Left ___Right ___Both

Does your child ever complain of fullness or ear pain? _____ ☐ YES ☐NO

Has your child been exposed to loud noise or an explosion? ☐ YES ☐ NO

Does your child lose balance or fall easily? ☐ YES ☐ NO

Does your child wear hearing aids? ☐ YES ☐ NO
If YES, Purchase date: _____ Make/Model: _____Which ear? ___Left ___Right ___Both

If you answered yes to any of the above questions, please describe: _____

**Child's Medical History**
At what age did child begin: Sitting: _____Crawling: _____Walking: _____Babbling_____

Your child's history of illness/medical condition (age of diagnosis):

| | | | |
|---|---|---|---|
| ___Measles/Mumps | ___Tonsillitis | ___Chicken Pox | ___Allergies |
| ___Neurofibromatosis | ___Frequent Colds/Flu | ___Scarlet Fever | ___High Fevers |
| ___Seizures | ___Meningitis | ___Head Injury | ___Encephalitis |
| ___RSV | ___Mastoiditis | ___Cerebral Palsy | ___Attention Deficit Disorder |
| ___Autism or Asperger's Syndrome | | ___Learning Disability | ___Impaired Vision |

If YES, please describe: _____

Please describe any other serious illness, injury or hospitalizations: _____
_____

Is your child currently under the care of a physician or specialist? ☐ YES ☐ NO
If YES, please describe: _____
Please list any medications your child is currently taking: _____

**Child's Speech and Language History**
How do you feel your child's speech, language and communications skills are developing? _____
_____

Age your child say their first word_____ Does your child understand what you say? _____

How does your child communicate with you? _____

Is your child receiving early intervention services or speech, occupational, or physical therapy? _____

Do you have any additional concerns or questions about your child's hearing, communication skills or overall

development? _____

**School Progress**
Is your child in school? _____ Where? _____ Grade: _____ Teacher's Name_____

How would you describe your child's academic performance? _____

Additional Comments: _____

_____