



PEDIATRIC AUDIOLOGY CASE HISTORY

Today's Date: _____

Who is filling out form? _____

Child's Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Have you ever questioned your child's ability to hear normally? Yes No

If yes, please describe: _____

How long have you noticed this problem? _____

Did your child pass his/her newborn hearing screening? **Right:** Yes No **Left:** Yes No

Has any other hearing test been completed since birth? Yes No

If yes: Where? _____ When? _____

Do any of the child's relatives have hearing problem? Yes No

If yes: Whom? _____ At what age was loss identified? _____

Has your child been diagnosed with any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Speech/language delays | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism or other Spectrum diagnosis |
| <input type="checkbox"/> Movement disorder | | |

Prenatal History

Please check any conditions that occurred during pregnancy:

- | | | |
|---|--|--|
| <input type="checkbox"/> Rh incompatibility | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> CMV | <input type="checkbox"/> Lack of oxygen | <input type="checkbox"/> Maternal x-rays/illness |
| <input type="checkbox"/> Rubella/German measles | <input type="checkbox"/> Infections | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Communicable diseases | <input type="checkbox"/> Medication | <input type="checkbox"/> Venereal diseases |

Birth History

Age of mother at birth: _____ Length of pregnancy: _____

Child's weight at birth: _____

Please check any of the conditions that occurred during or after birth:

- | | | |
|--|---|--|
| <input type="checkbox"/> Caesarian section | <input type="checkbox"/> Lack of oxygen | <input type="checkbox"/> Oxygen administered-mother |
| <input type="checkbox"/> Oxygen administered-child | <input type="checkbox"/> Medication given to child* | <input type="checkbox"/> Medication given to mother* |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Congenital defects | <input type="checkbox"/> Special neonatal care/NICU |
| <input type="checkbox"/> Ventilator | <input type="checkbox"/> Low APGAR scores | How long? _____ |

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

*Including antibiotics

Child's Hearing History

Has your child had recurrent middle/inner ear infections? Yes No
If yes, what treatments were used? _____
At what ages? _____
Does your child ever complain of pain or fullness in the ear(s)? Yes No
Has your child ever described noise in the ear? Yes No
Which ear? Right Left
Has your child ever been exposed to loud noises or an explosion? Yes No
Does your child fall or lose balance easily? Yes No
Describe: _____

Health History

Please check all that apply and **list date** of occurrence:

- | | | |
|--|---|---|
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Tonsillitis _____ | <input type="checkbox"/> Chicken pox _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Frequent colds _____ |
| <input type="checkbox"/> Scarlet fever _____ | <input type="checkbox"/> Ear infections _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> Sinusitis _____ | <input type="checkbox"/> Encephalitis _____ | <input type="checkbox"/> Draining ears _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Flu _____ | <input type="checkbox"/> High fevers _____ |
| <input type="checkbox"/> Head injury _____ | <input type="checkbox"/> Dizziness _____ | |

List any other serious illness, injury, or surgery: _____

Is your child currently under a physician's care? Yes No
If yes, for what reason? _____

Please list current medications: _____

Does your child have any open sores, bleeding, drainage, or contagious illness at this time? Yes No
Describe: _____

Speech & Language Development

How do you feel your child's speech, language, and basic communication skills are developing?

Is your child currently in speech, occupational, or physical therapy: ST OT PT

When did your child speak his/her first words? _____

Does your child understand what you say to him/her? Yes No

Please list any additional concerns or questions about your child's hearing, communication skills, or overall development? _____
