Pediatric Case History

Name: ____ Age: ________Sex: ___________ DOB: ________________

YES NO Do you have any concerns about your child's hearing? If yes, please describe:
____

YES NO Has your child been diagnosed with anything? If yes, please list diagnosis:
____

YES NO Has your child ever failed a hearing screening? If yes, when: ______________

YES NO Has your child had repeated ear infections? If yes, how many in the last year? ____

When was the last infection? ____

YES NO Has your child ever had pressure equalizing tubes? If yes, when: ___________

YES NO Were there any significant problems during pregnancy, delivery or following the birth of your child? If yes, please explain: ____

Hospital of birth: ____

YES NO Has your child had any serious illnesses or accidents requiring hospitalizations? If yes, please explain:
____

YES NO Does anyone in your child's family have hearing loss? If yes, which family member(s) and how old were they when their hearing loss began? ____

*****If you child is a pre-schooler, please complete the following; *****

How many different words does your child use? __________________________________

How many words does your child put together in a typical sentence? _________________

What percentage of your child's speech do you understand? ________________________

What percentage of your child's speech would a stranger understand? _______________

Parent/ Guardian Signature: ____ Date: _________________

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MEDICAL HISTORY: please check all that apply. Please provide the dates where applicable

- ☐ Dental cares / sealants current
- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atopic dermatitis / eczema
- ☐ Birth defect / genetic disorders _________
- ☐ Bladder infection
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chickenpox
- ☐ Congenital heart disease
- ☐ Constipation
- ☐ Contacts
- ☐ Cystic fibrosis
- ☐ Depression
- ☐ Immunization reaction
- ☐ Immunization refusal / delay
- ☐ Jaundice
- ☐ Kidney or bladder problems
- ☐ Learning problems
- ☐ Liver disease
- ☐ Meningitis
- ☐ Mononucleosis
- ☐ Neurologic problems
- ☐ Orthopedic problems
- ☐ OT/PT/Speech Therapy
- ☐ Developmental problems __________________
- ☐ Diabetes
- ☐ Emotional problems
- ☐ Frequent ear infections
- ☐ Frequent sinus infections
- ☐ Gastroesophageal reflux
- ☐ Glasses
- ☐ Hearing problems
- ☐ Heart murmur
- ☐ Hypothyroidism
- ☐ Overweight
- ☐ Pneumonia
- ☐ Prematurity _____
- ☐ Scoliosis
- ☐ Seizures/epilepsy
- ☐ Sensory integration disorder
- ☐ Sickle cell anemia or trait
- ☐ Skin conditions
- ☐ Strabismus
- ☐ Strep throat
- ☐ Tension or anxiety
- ☐ Trauma
- ☐ Tuberculosis
- ☐ UTI
- ☐ Vision problems
- ☐ Wheezing/reactive airway disease
- ☐ Other ____________
- ☐ Other ____________

What do you hope to get out of today's appointment?

____

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