PEDIATRIC AUDIOLOGICAL CASE HISTORY

PLEASE PRINT

Child's Name : _____

(Last Name) (First Name) (Middle Name)

Street Address: _____

City/State/Zip: _____

Telephone: Home/Primary: _____ Other_____

Gender (please circle) Male Female Birth Date:_____ Age:_____

Grade in School:_____ Name of Child's School, Preschool or Day Care:_____

Child's Physician:_____ Referring Physician:_____

Mother's Name:_____

Father's Name:_____

Name of Person Completing Questionnaire:_____

Relationship to Child:_____

Other Children in the Family:

Name:	Age:	Does He/She Have Speech/Hearing Problems?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there a history of hearing or speech problems during childhood in this child's family (grandparents, parents, siblings, uncles, aunts and/or cousins)? YES NO

If Yes, please specify/explain:

_____

_____

Patient Name_____ DOB_____

PRENATAL AND BIRTH HISTORY

Please describe any medical attention received by the child before or soon after birth:_____

_____

Please list any medications taken during pregnancy:_____

_____

Did the mother smoke, take drugs or use alcohol during the pregnancy? YES NO

IF yes, which and how often:_____

Results of Newborn Hearing Screening:_____Passed _____Referred _____None Completed

Length of Pregnancy:_____ Birth Weight_____

Describe any problems with the baby's breathing at birth: _____

Was the baby placed on any monitoring equipment? _____

Was the baby given any medication? _____

How long was the bay in the hospital? _____

Please describe any complications which occurred during or immediately following birth: _____

_____

_____

MEDICAL HISTORY

Please list any doctors, clinics, schools, hospitals or other agencies where your child has been seen. Include when your child was seen, the type of specialist, and any test results:

_____

At what age did the child begin:

Sitting_____ Crawling_____ Walking_____

Patient Name_____ DOB_____

What medications, if any, is the child currently taking? _____

_____

Please describe in detail any illnesses, conditions, or syndromes the child has been diagnosed with:

_____

_____

If the child has been back in the hospital since birth, please describe the circumstances (operation, accident, age of the child, etc.): _____

_____

HEARING ABILITY

Does your child have a hearing impairment? YES NO UNKNOWN

Does he/she use hearing aids or a cochlear implant? YES NO

Does this child:

Consistently respond to sounds?	YES	NO
Turn toward loud sounds?	YES	NO
Look when his/her name is called?	YES	NO
Enjoy listening to music?	YES	NO

Please explain why you are concerned about this child's hearing: _____

_____

When did you become concerned about this child's hearing? _____

Please provide any additional information you feel might be helpful in working with this child: _____

_____

_____

Patient Name_____ DOB_____

SPECIAL EDUCATION AND THERAPY:

Please indicate/describe any special education or therapy services this child has received: _____

_____

_____

Does this child's teacher have any concerns with his/her performance in school (if so, please describe):

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT

At Approximately what age did this child:

Say his/her first word? _____

Speak in three-word sentences? _____

How does the child express his/her needs (for example, ask for a drink): _____

_____