

Pediatric Audiologic Case History

Date _____

Child's Name _____ D.O.B. _____

Parent/Guardian's Name: _____

Primary MD: _____ Referring MD: _____

GENERAL

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

If yes, please describe _____

How long have you noticed this problem? _____

Has your child's hearing been tested before? Yes No

If yes: Where? _____ When? _____

What were the results? _____

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

If yes: Who? _____ Age of identification? _____

PRENATAL HISTORY

Please check any of the conditions that occurred during pregnancy:

<input type="checkbox"/> HIV	<input type="checkbox"/> Maternal illness/infection	<input type="checkbox"/> Lack of oxygen
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Rubella
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Cytomegalovirus (CMV)	<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Herpes

Were there any additional pregnancy complications? _____

BIRTH HISTORY

Length of pregnancy _____ Child's weight at birth _____

Prolonged hospital stay? _____ Apgar scores _____

Please check if any were applicable during delivery/after birth:

<input type="checkbox"/> Emergency cesarean	<input type="checkbox"/> Oxygen administered	<input type="checkbox"/> Phototherapy lights
<input type="checkbox"/> Mechanical ventilation	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Aminoglycoside antibiotics
<input type="checkbox"/> Congenital anomalies	<input type="checkbox"/> NICU stay	<input type="checkbox"/> Meconium aspiration
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Feeding tube	
<input type="checkbox"/> Other complications	<input type="checkbox"/> Syndrome _____	

Please describe _____

CHILD'S HEARING HISTORY

My child demonstrates the following auditory awareness. Please check all that apply:

<input type="checkbox"/> Startles to loud sounds	<input type="checkbox"/> Quiets to speech/music	<input type="checkbox"/> Awakens to loud sounds
<input type="checkbox"/> Turns to speech/sound	<input type="checkbox"/> Responds to "no"/name	<input type="checkbox"/> Follows directions

Has your child had a history of ear infections/ear drainage? Yes No

If yes, please describe _____

Has your child had medical/surgical treatment for his/her ears? Yes No

If yes, when? _____

Type of procedure _____

Does he/she ever complain of pain or fullness in the ears? Yes No

If yes, please describe _____

Has your child ever described noise in the ears? Yes No

If yes, please describe _____

Does your child fall or lose balance easily? Yes No

If yes, please describe _____

HEALTH HISTORY

Has your child experienced any of the following? If yes, please 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"/> Flu _____	<input type="checkbox"/> Meningitis _____
<input type="checkbox"/> Sinusitis _____	<input type="checkbox"/> Encephalitis _____	<input type="checkbox"/> High fevers _____
<input type="checkbox"/> Seizures _____	<input type="checkbox"/> Head injury _____	<input type="checkbox"/> Blood transfusion _____

Any other serious illness or surgery? Yes No

If yes, please describe _____

Does your child have any developmental delays? Yes No

Age sat without support _____

Age walked without support _____

Additional comments _____

Is your child currently receiving occupational or physical therapy? Yes No

If yes, where and how often? _____

Please list any medications as well as dosage and frequency (including non-prescriptions) your child is currently taking or has taken recently _____

SPEECH-LANGUAGE DEVELOPMENT

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

My child is using (check all that apply):

<input type="checkbox"/> Cooing	<input type="checkbox"/> Babbling	<input type="checkbox"/> Single words
<input type="checkbox"/> 1-2 word phrases	<input type="checkbox"/> 3 word sentences	<input type="checkbox"/> Full sentences

Age of your child's first word _____

How many words would you estimate your child uses? _____

How intelligible are his/her words? _____

If your child is not using words, how does he/she convey his/her wants and needs? _____

Does your child follow directions? Yes No Comments _____

Does your child answer questions appropriately? Yes No Comments _____

Is your child currently receiving speech therapy services? Yes No Comments _____

Are there multiple languages spoken in the home? Yes No

If yes, what languages? _____

Additional comments or concerns: