

Northwest Ohio Hearing Clinic

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Pediatric Case History – Audiology

Today's Date _____

Last Name: _____ First Name: _____ M.I. _____

Birthdate: _____ Age: _____ Grade in School: _____ Gender: M F

Child's Physician: _____ Physician's Phone: _____

Who may we thank for referring you? _____

With whom may we discuss the results of the evaluation? _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work or Cell Phone: _____

Name of person completing questionnaire: _____

Relationship to child: _____

Are the parents: Single Married Separated Divorced Foster Care Adoptive Deceased

Name of child's school, preschool, or daycare? _____

Please describe the reason for your child's visit: _____

Where would you like us to send the results of today's evaluation?

Prenatal and Birth History

Please List any medications taken during pregnancy: _____

Please indicate in which month of the pregnancy any of the following conditions occurred:

German Measles: _____ Rubella: _____ Toxoplasmosis: _____
Herpes: _____ Bad Fall: _____ Cytomegalovirus (CMV) _____
Syphilis: _____ Car Accident: _____ Kidney Infection: _____

Describe any medical attention received by the child before, during, or soon after birth: _____

Did the mother smoke, take recreational drugs, or use alcohol during the pregnancy? Yes No

If yes, which one(s): _____

How often: _____

Hospital child was born in: _____

Results of newborn hearing screening (circle): Passed Referred None completed

What was the child's Apgar score (1-10)? _____

Length of pregnancy: _____ Birth weight: _____

Were any injuries, scars, or deformities noted at birth? Yes No

Was the baby given any medication or placed on any monitoring equipment? Yes No

If yes, please describe? _____

Medical History

At what age did the child begin: _____ Sitting _____ Crawling _____ Walking

Please provide the approximate ages at which this child had any of the following illnesses:

Asthma _____

Encephalitis _____

Meningitis _____

Chicken Pox _____

Exposure to loud noise _____

Mumps _____

Frequent Colds _____

German Measles _____

Pneumonia _____

Concussion _____

Severe Headaches _____

Rubella _____

Hepatitis _____

Sinusitis _____

CMV* _____

High Fevers _____

Dizziness _____

Head Trauma _____

Mastoiditis _____

RSV* _____

TB* _____

*CMV – Cytomegalovirus

*RSV – Respiratory Syncytial Virus

*TB - Tuberculosis

Earaches or Ear Infections _____

Surgery _____

Other _____

Comments _____

Please indicate whether this child has been diagnosed with a syndrome or other permanent medical condition: (check all that apply)

___ Allergies

___ Hyperactivity

___ Attention Deficit Disorder

___ Cancer

___ Impaired Vision

___ Immune Deficiency Disorder

___ Diabetes

___ Tinnitus

___ Autism or Asperger's Syndrome

___ Kidney Disease

___ Cerebral Palsy

___ Emotional/Behavior Disorder

___ Cleft Palate

___ Seizures/Convulsions

___ Neurofibromatosis

___ Developmental Disability

___ Learning Disability

___ Other: _____

Please describe: _____

If the child has been hospitalized since birth, please describe the circumstances: _____

Please check any medications your child is on or has taken:

___ Vancomycin

___ Gentamycin

___ Lasix

___ Chemotherapy

___ Radiation

___ Streptomycin

___ Other: _____

What medication is your child currently taking? _____

Special Education and Therapy

Please indicate any special education or therapy services this child has received: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Bilingual Education | <input type="checkbox"/> Occupational (OT) | <input type="checkbox"/> Physical (PT) |
| <input type="checkbox"/> Use of FM System | <input type="checkbox"/> Special Education | <input type="checkbox"/> Speech Language Therapy |
| <input type="checkbox"/> Social Services | <input type="checkbox"/> Reading Specialist | <input type="checkbox"/> Early Childhood Education |
| <input type="checkbox"/> Deaf Education | <input type="checkbox"/> Interpreting | <input type="checkbox"/> Teacher of the Hearing Impaired |
| <input type="checkbox"/> Other _____ | | |

Speech and Language Development

At approximately what age did this child:

Speak his/her first word? _____

Speak in three word sentences: _____

How much of the child's speech can be understood:

By the family? _____

By others? _____

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

Does this child use a system of communication other than speaking and listening?

(for example, sign language, cued speech, a communication board, etc.) Yes No

If so, what type? _____

Hearing Ability

Does your child have a hearing impairment? Yes No

Does he/she use hearing aids or a cochlear implant? Yes No

If so, what type? _____

(Please bring to appointment)

Does the 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 any concerns you have regarding the child's hearing: _____

Is there a history of hearing or speech problems during childhood in this child's family? Yes No

If so, please describe: _____