Pediatric Case History Form

Patient Name: _____ DOB: _____

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

Have you ever questioned your child's ability to hear normally? ☐ YES ☐ NO

If yes, please explain: _____

How long have you noticed this problem? _____

Has your child's hearing been tested? ☐ YES ☐ NO

If yes: Where? _____ When? _____

Does any of the child's relatives have hearing problems? ☐ YES ☐ NO

If yes: Who? _____ At what age was the problem identified? _____

PRE-NATAL HISTORY

Please check any of the following conditions that occurred DURING the mother's pregnancy:

- ☐ RH Incompatibility
- ☐ CMV
- ☐ Rubella / Measles
- ☐ Infections
- ☐ Substance Abuse
- ☐ Lack of Oxygen
- ☐ Communicable Disease
- ☐ Medication taken
- ☐ Alcohol Abuse
- ☐ Maternal X-rays / Illness
- ☐ Toxemia
- ☐ Venereal Disease / STD

BIRTH HISTORY

Age of Mother at Child's Birth: _____ Length of Pregnancy: _____

Child's Weight at Birth: _____ APGAR Score: _____

Please check any of the conditions that occurred DURING of the child's birth:

- ☐ Caesarean
- ☐ Medication Given to Child
- ☐ Oxygen Administered (Mother / Child
- ☐ Lack of Oxygen
- ☐ Congenital Abnormality
- ☐ Medication Given to Mother
- ☐ Jaundice / Hyperbilirubinemia
- ☐ NICU Stay Required

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

_____

_____

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CHILD'S HEARING HISTORY

Has your child had medical/surgical treatment for ears? (example: PE tubes) ☐ YES ☐ NO

If yes, at what age? _____ What procedure? _____

Does your child ever complain of pain or fullness in the ear(s)? ☐ YES ☐ NO

Has your child ever descried noises in the ear(s)? ☐ YES ☐ NO

If yes, which ear? ☐ RIGHT ☐ LEFT

Has your child ever been exposed to loud noises? (example: gunfire or explosions) ☐ YES ☐ NO

Does your child fall or lose balance easily? ☐ YES ☐ NO

HEALTH HISTORY

Please check all that apply and LIST DATE OF OCCURRENCE:

- ☐ Measles _____
- ☐ Allergies _____
- ☐ Scarlet Fever _____
- ☐ Sinusitis _____
- ☐ Seizures _____
- ☐ Head Injury _____
- ☐ Tonsillitis _____
- ☐ Mumps _____
- ☐ Ear Infections _____
- ☐ Encephalitis _____
- ☐ Flu _____
- ☐ Other: _____
- ☐ Chicken Pox _____
- ☐ Frequent Colds _____
- ☐ Meningitis _____
- ☐ Draining Ears _____
- ☐ High Fever _____

Did your child meet gross motor skill milestones typically? (example: walking) _____

Is your child currently (or has been recently) under a physician's care? ☐ YES ☐ NO

If yes, what is the reason? _____

Please list current medications for your child is prescribed/ taking: _____

_____

SPEECH AND LANUAGE DEVELOPMENT

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

_____

Is your child currently receiving Speech, Occupational, or Physical therapies? _____

At what age was your child's first words? _____ How many words does your child currently use? _____

Does your child follow multi-step directions? (example: Get your shoes and bring them to me.) _____

Additional concerns: _____

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