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) _____

Syphillis: _____ 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 _____
Chicken Pox _____
Frequent Colds _____
Concussion _____
Hepatitis _____
High Fevers_____
Mastoiditis _____
***CMV – Cytomegalovirus**

Encephalitis_____
Exposure to loud noise_____
German Measles_____
Severe Headaches_____
Sinusitis_____
Dizziness_____
RSV*****_____
***RSV – Respiratory Syncytial Virus**

Meningitis _____
Mumps _____
Pneumonia_____
Rubella _____
CMV***** _____
Head Trauma _____
TB***** _____
***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
____ Cancer
____ Diabetes
____ Kidney Disease
____ Cleft Palate
____ Developmental Disability
____ Other:_____

____ Hyperactivity
____ Impaired Vision
____ Tinnitus
____ Cerebral Palsy
____ Seizures/Convulsions
____ Learning Disability

___ Attention Deficit Disorder
___ Immune Deficiency Disorder
___ Autism or Asperger's Syndrome
___ Emotional/Behavior Disorder
___ Neurofibromatosis

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)

___ Bilingual Education ___ Occupational (OT) ___ Physical (PT)

___ Use of FM System ___ Special Education ___ Speech Language Therapy

___ Social Services ___ Reading Specialist ___ Early Childhood Education

___ Deaf Education ___ Interpreting ___ Teacher of the Hearing Impaired

___ 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:_____