LIVE BETTER HEARING

www.LiveBetterHearing.com

Updated 03/9/2018

PEDIATRIC CASE HISTORY
(For Children Ages 5 through 18 years)

Child's full name: _____ Date of birth: _____

Mother's full name: _____ Child's sex: Female Male

Father's full name: _____

Legal guardian's full name: _____

Person completing this form: _____

Please describe the reason for the child's visit to the office: _____

_____

Any complications during pregnancy or delivery? Yes No If so, please explain. _____

_____

_____

_____

MEDICATIONS Please list all medications, vitamins, or drugs ***taken during pregnancy and delivery***

Name of medication	What was the medication taken for?

Is the child currently taking any of the following medications? (please check all that apply)

_____ Vancomycin _____ Gentamycin _____ Radiation

_____ Chemotherapy _____ Other: _____

_____

MEDICATIONS Please list all the child's ***current medications and vitamins***

Name of medication	What is the medication taken for?

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Known risk factors (please check all that apply)

_____ Family history of hearing loss

_____ Head trauma requiring hospitalization

_____ Confirmed bacterial meningitis

_____ Hyperbilirubinemia/jaundice (requiring exchange transfusion)

_____ Anatomic malformation of head, face, or neck (e.g., dysmorphic appearance, cleft lip or palate, abnormalities of ear such as microtia, atresia, or periauricular tags/pits)

_____ CHARGE syndrome

_____ Pulmonary hypertension

_____ Trisomy 21 (Down syndrome)

_____ Other conditions/diagnoses: _____

_____

_____

Does the child have siblings? Yes No

If yes, please list all siblings and their ages _____

_____

_____

Has the child had a fever greater than 104° F? Yes No

If yes, at what age and how long did the high fever last? _____

_____

_____

Has the child ever been hospitalized? Yes No

If yes, what procedures/treatments were performed? _____

_____

_____

Has the child ever been seen by a specialist of physician other than the pediatrician? Yes No

Who? _____ When? _____

Reason? _____

Outcome? _____

Do you have concerns regarding the child's hearing? Yes No

If yes, please explain, including when this was first noticed: _____

_____

_____

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What were the results of your child's Universal Newborn Hearing Screening?

_____ Passed both ears _____ Referred left ear only

_____ Referred both ears _____ Referred right ear only

When was the child's last hearing evaluation? _____

What were the results? _____

_____

How many ear infections has the child had? _____ When was the last infection? _____

How is it/are they treated? _____

Has your child ever had tubes placed in his/her ears? _____

How does the child communicate with others? _____

(e.g. spoken English, spoken Spanish, ASL, cued speech, total communication, etc.)

At approximately what age did the child:

Say his/her first word? _____Yrs. _____Mos.

Speak in three word sentences? _____Yrs. _____Mos.

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

By the family? Yes No Sometimes Explain: _____

By others? Yes No Sometimes Explain: _____

Do you have concerns regarding your child's speech/language development? Yes No

If yes, please explain: _____

_____

Does the child receive speech/language services or therapy? Yes No

If yes, where? _____From whom? _____

How often? _____times per week Appointment length: _____minutes

Do you have concerns regarding the child's physical development or balance? Yes No

If yes, please explain: _____

_____

Does the child receive physical therapy? Yes No

If yes, where? _____From whom? _____

How often? _____times per week Appointment Length: _____minutes

Are there any concerns for and/or diagnoses of Attention Deficit Disorders?

If yes, please explain: _____

_____

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Please explain any other pertinent information that you would like the audiologist to know: