LIVE BETTER HEARING
www.LiveBetterHearing.com

Updated 03/2018

PEDIATRIC CASE HISTORY
(For Children Ages 6 months to 4 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: _____

_____

PREGNANCY & BIRTH HISTORY

Length of pregnancy: _____weeks Birth weight: _____lbs. _____oz.
Hospital of delivery: _____
Type of delivery: _____ Was labor induced? Yes No
Did the child spend any time in the NICU? Yes No If so, how long? _____
Any complications during pregnancy or delivery? Yes No If so, please explain? _____

_____

What was the child's Apgar score? 1 2 3 4 5 6 7 8 9 10

Did any of the following occur during pregnancy? (please check all that apply)

_____ German measles _____ Rubella _____ Toxoplasmosis
_____ Cytomegalovirus (CMV) _____ Herpes _____ Drinking/drug use
_____ Syphilis _____ Smoking _____ Kidney infection

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

Name of medication	What is the medication taken for?

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

_____ Vancomycin _____ Gentamycin _____ Radiation _____ Streptomycin
_____ Chemotherapy _____ Other: _____

_____

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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? _____

DEVELOPMENTAL MILESTONE

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

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

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

_____ Passed both ears
_____ Referred both ears
_____ Referred left ear only
_____ Referred right ear only

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Does the child... Consistently respond to sounds? Yes No Respond to his/her name? Yes No
Turn to find a sound source? Yes No Enjoy listening to music? Yes No
Startle to loud noise? Yes No

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
At approximately what age did the child:
Hold his/her head erect: _____Yrs. _____Mos.
Sit unsupported: _____Yrs. _____Mos.
Walk alone: _____Yrs. _____Mos.
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
Does the child attend Day Care/Preschool? Yes No
Where? _____
How often? _____

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