Sacred Heart UNIVERSITY *Audiology Clinic*

Pediatric Case History

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for Today's visit _____

Referred by _____

Child lives with: ☐ both parents ☐ Mother ☐ Father ☐ other

Names and ages of any other children at home: _____

Name and Address of Child's School, Preschool or Child Care Setting

_____

GENERAL MEDICAL

1. Do you have any medical concerns about your child? ☐ **YES** ☐ **NO**
If yes, briefly explain: _____

_____

2. Please check if your child has had any of the following:

Ear infections	☐	Meningitis	☐	Seizures	☐
Ear surgery	☐	Measles	☐	Kidney problems	☐
Hospitalization	☐	Mumps	☐	Vision problems	☐
Head trauma/injury	☐	Chicken pox	☐	Allergies	☐
Noise exposure (e.g. farm equipment, loud music)	☐	Asthma	☐		

Briefly explain any you checked: _____

_____

3. Please list any prescription or over-the-counter medications your child is taking and for what reason(s): _____

_____

4. Has your child ever experienced **head trauma**? ☐ **YES** ☐ **NO**

5. Has your child ever had surgery on his/her ear(s), nose, or throat? ☐ **YES** ☐ **NO**

HEARING (*Please fill in the blanks or check where appropriate*)

1. Do you have any concerns about your child's hearing? ☐ **YES** ☐ **NO**
If yes, briefly explain: _____

2. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30? ☐ **YES** ☐ **NO** If yes, who? _____

4. Does your child consistently respond to your voice? ☐ **YES** ☐ **NO**

5. Does your child respond to loud noises? ☐ **YES** ☐ **NO**

6. When sound is present or someone is speaking, does your child search to find where the sound is coming from? ☐ **YES** ☐ **NO**

7. Does your child respond to sounds from other rooms? ☐ **YES** ☐ **NO**

8. Does your child enjoy listening to music? ☐ **YES** ☐ **NO**

9. Has your child's hearing ever been tested? ☐ **YES** ☐ **NO**
If yes, please list by whom, when and results _____

10. Does your child wear hearing aid(s)? ☐ **YES** ☐ **NO**
If yes, when was your child first fit?_____

11. Does your child receive preferential classroom seating? ☐ **YES** ☐ **NO**

Pregnancy And Birth History *(please check YES or NO)*

1. Was the pregnancy abnormal in any way? ☐ **YES** ☐ **NO**

2. Was the delivery abnormal in any way? ☐ **YES** ☐ **NO**

3. Was the delivery premature? ☐ **YES** ☐ **NO**

4. Did the mother have any illness during the pregnancy? ☐ **YES** ☐ **NO**

5. Did the mother take any medication during the pregnancy? ☐ **YES** ☐ **NO**

6. After birth, did your child have:

- Breathing difficulties? ☐ **YES** ☐ **NO**
- Require an incubator? ☐ **YES** ☐ **NO**
- Any head, neck or ear abnormalities? ☐ **YES** ☐ **NO**
- Feeding problems? ☐ **YES** ☐ **NO**
- Surgery? ☐ **YES** ☐ **NO**
- Any infections requiring medication? ☐ **YES** ☐ **NO**
- Treatment for jaundice (yellow coloration of the skin)? ☐ **YES** ☐ **NO**

If yes to any of the above, briefly explain: _____
_____
_____