AUDIOLOGY ASSOCIATES
hear today, hear tomorrow

Pediatric Case History

PATIENT INFORMATION

I, _____ the undersigning parent/person having legal custody/guardianship of _____ a minor, do hereby authorize, request and direct Audiology Associates to perform in judgement any examination and audiologic diagnosis or treatment which is deemed necessary.

Parent/Guardian Printed Name _____

Signature _____ Date _____

MEDICAL HISTORY

Did your child have an infection at birth? _____

☐ None ☐ Cytomegalovirus ☐ Rubella ☐ Herpes ☐ Syphillis ☐ Toxoplasmosis

Did your child have asphyxia or breathing problems at birth? ☐ YES ☐ NO

Were any blood transfusions given? ☐ YES ☐ NO

If yes, please describe: _____

Was your child in an intensive care unit? ☐ YES ☐ NO

Were there any congenital malformations involving the head, neck, or ears? ☐ YES ☐ NO

What was your child's birth weight? _____

Was your child born prematurely? ☐ YES ☐ NO

If yes, how many weeks? _____

Was your child treated with any antibiotics? ☐ YES ☐ NO

If yes, what kind? _____

Did your child ever have meningitis? ☐ YES ☐ NO

If yes, at what age? _____

Did your child have elevated bilirubin (jaundice)? ☐ YES ☐ NO

Did your child pass a newborn hearing screening? ☐ YES ☐ NO

Is there a family history of hearing problems in early childhood? ☐ YES ☐ NO

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother

☐ Sister ☐ Uncle ☐ Aunt ☐ Cousin ☐ Other

Does your child have any other associated disability? ☐ YES ☐ NO

☐ Blindness or vision disorder ☐ Cerebral Palsy ☐ Developmental disability

☐ Seizure ☐ Down Syndrome ☐ Learning Disability Other: _____

When did you last consult a physician about your child's ears? _____

Any recent illnesses? ☐ YES ☐ NO

If yes, what? _____

Has your child had any earaches? ☐ YES ☐ NO

If yes, which ear(s)? ☐ LEFT ☐ RIGHT ☐ BOTH

Have their ears been medically treated? ☐ YES ☐ NO

If yes, which ear(s)? ☐ LEFT ☐ RIGHT ☐ BOTH

Is your child receiving any medication? ☐ YES ☐ NO

If yes, what kind? _____

Has your child experienced dizziness? ☐ YES ☐ NO

Has your child had a history of high fever? ☐ YES ☐ NO

HEARING AND SPEECH HISTORY

Do you think your child has a hearing problem? ☐ YES ☐ NO

If yes, how old was your child when you first noticed a hearing loss? _____

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

Does your newborn startle at loud sounds? ☐ YES ☐ NO ☐ N/A

Does your three-month-old stop moving or crying when you call them? ☐ YES ☐ NO ☐ N/A

Does your six-month-old enjoy noise-making toys? ☐ YES ☐ NO ☐ N/A

Does your nine-month-old babble frequently? ☐ YES ☐ NO ☐ N/A

Does your one-year-old respond to simple commands? ☐ YES ☐ NO ☐ N/A

At what age did your child first babble? _____

At what age did your child say their first word? _____

At what age did your child start speaking short (2-3 word) sentences? _____

How many words does your child have in their vocabulary? _____

How often does your child use speech?

☐ Frequently ☐ Occasionally ☐ Seldom ☐ Never ☐ N/A

Is your child's speech clear? ☐ YES ☐ NO ☐ N/A

How did you hear about our services?

☐ Doctor's Referral ☐ Advertisement ☐ School ☐ Friend ☐ Yellow Pages

☐ Previous Patient ☐ Other _____

HEARING AND SPEECH HISTORY

I authorize _____ to release any part or all of my records to the persons listed below:

	Name	Address
1.		
2.		
3.		

Signature: _____ **Date:** ____ / ____ / ____

Print Name: _____ **Relationship to Patient:** _____