Child Case History

Name____________________ Date_______
Age_____

For what reason was this hearing test arranged?
____
____
____

Has your child ever had a hearing test before? YES NO
If so, when and where?____

Do you have any concern about your child's hearing? YES NO

Does your child seem to hear better on some days than others? YES NO

Does anyone in your family have problems with hearing? YES NO

Were any of the following present after your child's birth or during the first two months?

__ Prematurity

__Appeared Yellow

__Poor weight gain

__Stayed in Hospital after mother went home

__Was in incubator

__Infections at birth

__Did not pass hearing screening at birth

__Physical deformities

__Difficulty breathing

__High fever

__Birth weight less than 5 lbs

Does your child turn toward sound? __ Yes __ No

Has your child had ear infections? __ Yes __ No How Many?____

Has your child had tubes placed in the ear(s) __ Yes __No If so, which ear ___

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