PEDIATRIC CASE HISTORY FORM

Child's Name: _____ **DOB** _____ **Age** _____

Chief Complaint: _____
PRIMARY PHYSICIAN: _____

Hearing History **YES NO**

1. Do you have concerns about your child's hearing?
If yes, briefly explain _____
2. Does anyone in the child's immediate or extended family (blood relation) have hearing loss that began before the age of 30? Relation _____
3. Does your child wear hearing aids or use an auditory trainer? (Circle one, if yes)

Pregnancy and Birth History

1. Was the pregnancy/delivery of this child abnormal in any way?
If yes, please explain _____
2. Did your child stay in the NICU for any duration after birth?
3. Was there a history of drug use or STD during pregnancy?
If yes, please explain _____

Speech/Language History

1. Do you have any concerns about your child's speech and language?
If yes, please explain _____
2. Is your child currently receiving speech therapy?

Medical History

1. Do you have any medical concerns about your child?
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 _____

3. Is your child in any pain? If so, rate from 1 to 10 (10 being most severe) _____
4. Is your child on any medications? If so, please list _____
5. Were you taking any medications while pregnant? If so, please list:
_____

Additional History

1. Do you have any other concerns about your child?
If yes, briefly explain _____
2. Does your child:
Play/interact well with other children?
Have attention/concentration difficulties?
Receive any special education services?
Name of School: _____
Grade your Child is currently in: _____

_____ _____ _____
Parent or Guardian's Signature Relationship Date