Child Case History

(For patients up to age 16)

Patient Name _____ Age _____ Date _____

1. For what reason was this hearing test scheduled?

_____Speech/language delay ____Failed hearing screening _____Other (specify _____)

2. Has your child ever had a hearing test before? Yes _____ No_____
   If so, when and where? _____

3. Do you have any concerns about your child's hearing? Yes _____ No_____

4. Does your child seem to hear better on some days than others? Yes _____ No_____

5. Does anyone in child's family have hearing loss? Yes _____ No_____

6. Has your child been exposed to very loud sounds? Yes _____ No_____
   If yes, explain. _____

7. Does your child report any ringing in the ears? Yes _____ No_____

8. Does your child report any dizziness? Yes _____ No_____

9. Does your child respond to everyday sounds? Yes _____ No_____

10. Has your child had ear infections? If Yes, how many? _____ Yes _____ No_____

11. Has your child had tubes placed in the ear(s) Yes _____ No_____
    If yes, when? _____

12. Does your child take any medications? Yes _____ No_____
    If yes, please list. _____
    _____

13. Does your child use recreational drugs? Yes _____ No_____
    If so, which ones and how often? _____
    _____

Please check all that apply regarding your child:

____Premature birth ____Jaundice (appeared yellow) ____Developmental delay

____Required oxygen at birth ____Failed Newborn Hearing Test ____Physical malformation of ears

____High fever (104^{o} or higher) ____Chronic illness: Explain:_____