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DOSS AUDIOLOGY & HEARING CENTER

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PEDIATRIC CASE HISTORY

To fill out this form and print, open in Adobe Reader or your web browser of choice.

The following information is confidential. **Today's Date: ___/___/_____**

1. PATIENT INFORMATION

Child's Name _____ **D.O.B** ___/___/_____
Last *First* *Middle*

2. BIRTH & PRENATAL HISTORY

Birth weight: Premature? ☐ **Yes** ☐ **No** **If yes, How Many Weeks?** _____

Place of Birth (City and Hospital): _____

Relationship to Patient: _____

Is your child receiving services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No

At birth did the baby have the following: (please check)

Anoxia (blue color)	☐ Yes ☐ No	Respiratory distress	☐ Yes ☐ No
Jaundice (yellow color)	☐ Yes ☐ No	Swallowing or Sucking Problems	☐ Yes ☐ No

3. SPEECH AND LANGUAGE DEVELOPMENT

Can you understand your child's speech? ☐ Yes ☐ No
Can other people understand your child's speech? ☐ Yes ☐ No
Is your child in speech therapy or being evaluated for speech therapy? ☐ Yes ☐ No

4. MEDICAL HISTORY

1. Does your child have a medical diagnosis (i.e. Down Syndrome, Autism, Cerebral Palsy, ADHD)? ☐ Yes ☐ No
If yes, briefly explain: _____

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

☐ **Ear infections** ☐ **Meningitis** ☐ **Seizures** ☐ **Measles** ☐ **Kidney problems** ☐ **Hospitalization**
☐ **Mumps** ☐ **Vision problems** ☐ **Head trauma/injury** ☐ **Chicken pox** ☐ **Allergies**
☐ **Ear surgery – Please Explain:** _____

3. Do you have a family history of hearing loss? ☐ Yes ☐ No **If yes, relation:** _____

5. HEARING HISTORY

Did your child pass their newborn hearing screening? ☐ Yes ☐ No
Has your child recently failed a hearing screening? ☐ Yes ☐ No
If Yes, Which ear? ☐ Right ☐ Left **When:** _____
Are you concerned about your child's hearing? ☐ Yes ☐ No
If Yes, Please Explain: _____