THE HEARING CLINIC

PEDIATRIC CASE HISTORY

Today's Date: _____

Child's Name: _____ DOB: _____

Mother's Name: _____ Father's Name:_____

Have you ever questioned your child's ability to hear normally? **YES** **NO**

If yes, please describe:_____

_____

How long have you noticed this problem? _____

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

If yes: Where? _____ When? _____

Do any of the child's relatives have hearing problems? **YES** **NO**

If yes: Who? _____ What age was the loss identified?_____

Pre-Natal History

Please check any of the conditions that occurred during pregnancy:

☐ Rh incompatibility	☐ Substance abuse	☐ Alcohol abuse	☐ CMV
☐ Lack of oxygen	☐ Maternal X-rays/illness	☐ Rubella/German measles	☐ Medication
☐ Infections	☐ Toxemia	☐ Communicable diseases	☐ Venereal disease

Birth History

Age of mother at birth: _____ Length of pregnancy: _____

Child's weight at birth: _____ Apgar scores: _____

Please check any of the conditions that occurred during pregnancy:

☐ Caesarean ☐ Lack of oxygen ☐ Oxygen administered–mother/child ☐ Medication given to child
☐ Congenital defects ☐ Medication given to mother ☐ Jaundice ☐ Special neonatal care/NICU

If you checked any of the conditions above, please describe: _____

_____

24001 ORCHARD LAKE ROAD · SUITE 170 · FARMINGTON, MI · 48336 · 248-881-3026
2300 GENOA BUSINESS PARK DRIVE · SUITE 130 · BRIGHTON, MI · 48114 · 810-225-2205
WWW.HEARINGCLINICONLINE.COM · THEHEARINGCLINIC1@GMAIL.COM · FAX: 810-225-2209

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Child's Hearing History

Has your child had medical or surgical treatment for their ears, such as P.E. tubes? _____

At what age(s)? _____

Does he/she ever complain of pain or fullness in the ear?		**YES**	**NO**
Has your child ever described noise in the ear?		**YES**	**NO**
	Which ear?	**Right**	**Left**
Has he/she ever been exposed to loud noises or an explosion ?		**YES**	**NO**
Does your child fall or lose balance easily?		**YES**	**NO**

Health History

Please circle all that apply and list date of occurrence:

ILLNESS	DATE
MEASLES	
TONSLLITIS	
CHICKEN POX	
ALLERGIES	
MUMPS	
FREQUENT COLDS	
SCARLET FEVER	
EAR INFECTIONS	

ILLNESS	DATE
MENIGITIS	
SINUSITIS	
ENCEPHALITIS	
DRAINING EARS	
SEIZURES	
FLU	
HIGH FEVERS	
HEAD INJURY	

Any other serious illness or surgery?

_____

Is he/she currently (or recently) under a physician's care? **YES** **NO**

List medications your child is currently taking:

_____

Does your child have any open sores, bleeding or drainage at this time? **YES** **NO**

Describe: _____

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PEDIATRIC CASE HISTORY

Speech-Language Development

How do you feel your child's speech, language and basic communication skills are developing?

_____

Is your child currently in speech, occupational or physical therapy? _____

When did he/she speak their first words? _____

Approximately how many words does your child speak or understand? _____

Does your child understand what you say to him/her? **YES** **NO**

Age and Sex of Siblings if appropriate _____

Do you have any additional concerns or questions about your child's hearing, communication skills or overall development?

_____

_____

Check those which apply to your child's communication:

_____ Does not understand what is said

_____ Understands very little of what is said

_____ Understands what is said if the speaker gestures

_____ Understands clearly everything that is said

_____ Child's speech is clearly understandable

_____ Does not use speech or gesture to communicate

_____ Uses gestures or motions, but not speech

_____ Uses speech, but limited amounts

_____ Puts one or two words together to communicate

_____ Does not use sentences