Comprehensive PEDIATRIC Case History Form

Name: _____Date:_____ Date of Birth: _____ M / F

Did your pediatrician or other physician refer you here? YES NO (circle one)

If YES, when was the last time the child was examined by the physician?_____

Audiologic History

Does your child experience hearing loss? Yes No If so, which ear? Right Left Both

If you suspect hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your child's hearing loss?: _____

What do you think is the cause of the hearing loss?: _____

Has your child ever had a hearing test? Yes No If so, when? _____ _____

Passed / Failed new born hearing screening? _____ Name of the hospital _____

Please check all medical conditions that apply:

_____ Developmental Disorders/Delays: Explain _____

_____ Dizziness or Unsteadiness

_____ Ear Deformity: Right ear Left ear Both ears

_____ Ear Drainage: Right ear Left ear Both ears

_____ Ear Pain: Right ear Left Ear Both ears

_____ Family History of Hearing Loss: Who? _____

_____ History of Ear Infections Right ear Left ear Both ears Last infection: _____

_____ History of Ear Wax Buildup

_____ History of Noise Exposure: Describe: _____

_____ Previous Ear Surgery Right ear Left ear Both ears When?_____

_____ Tinnitus/Ringing/Noises in ears: Right ear Left ear Both ears Frequency?_____

_____ Speech Disorder / Delay

_____ Failed Previous Hearing Examination

Other: Please describe:_____

Pregnancy Information

Was the pregnancy full term? YES NO If NO, how early was the delivery?_____

Did the baby require oxygen at birth? YES NO

Was the baby Jaundiced? YES NO If YES, did treatment require a blood transfusion? YES NO

Were there any other problems noted at birth? YES NO

If yes, What problems? _____

_____

Please list any medication taken during the pregnancy: _____

_____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence: _____

_____

Allergies (food, medications, plastics, etc.): _____

Has the PATIENT experienced any of the following major medical conditions (please check all that apply)

_____ AIDS/HIV
_____Kidney Problems
_____High Blood Pressure
_____Mumps
_____Encephalitis
_____High Fevers
_____Scarlet Fever
_____ Measles
_____Influenza
_____Stroke
_____Blood Disorders
_____Genetic Disorders
_____ Other: _____

_____ Meningitis
_____ Heart Problems
_____ Vascular Problems
_____ Diabetes
_____ Head Injury
_____ Chicken Pox
_____ Typhoid
_____ Malaria
_____ Cancer
_____Tonsillitis
_____ Headaches
_____ Exposed to second hand smoke

Current Medications (over the counter and prescriptions): _____

_____

_____

_____