PEDIATRIC CASE HISTORY – AUDIOLOGY

Today's Date: _____

Patient's Name: _____

Birthdate: _____ Age: _____ Grade in School: _____ Gender: M F

Who may we thank for referring you?

_____

With whom may we discuss the results of the evaluation?

_____

_____

_____

Mother's Name: _____

Father's Name: _____

Name of person completing questionnaire:

_____

Relationship to Child:

_____

Please describe the reason for your child's visit:

_____

_____

_____

_____

_____

_____

PRENATAL AND BIRTH HISTORY

1. Please list any medications taken during pregnancy: _____
_____

2. Please indicate in which month of the pregnancy any of the following conditions occurred:
German Measles: _____ Rubella: _____ Toxoplasmosis: _____
Herpes: _____ Bad Fall: _____ Cytomegalovirus (CMV): _____
Syphilis: _____ Car Accident: _____ Kidney Infection: _____

3. Describe any medical attention received by the child before, during, or soon after birth:
_____
_____
_____

4. Did the mother smoke, take recreational drugs, or use alcohol during the pregnancy?
___ Yes ___No
If yes, which one(s): _____
How often: _____

5. Hospital child was born in:
_____

6. Results of newborn hearing screening (circle): Passed Referred None completed

7. What was the child's Apgar score (1-10)?_____

8. Length of pregnancy (weeks): _____ Birth weight: _____

9. Were any injuries, scars, or deformities noted at birth? _____Yes _____No

10. Was the baby given any medication or placed on any monitoring equipment?
___ Yes ___ No
Please describe:_____

MEDICAL HISTORY
1. At what age did the child begin: _____Sitting _____Crawling _____Walking

2. Please provide the approximate ages at which this child had any of the following illnesses:

Asthma _____	Encephalitis _____	Meningitis _____
Chicken Pox _____	Exposure to loud noise_____	Mumps _____
Frequent Colds _____	German Measles _____	Pneumonia _____
Concussion _____	Severe Headaches _____	Rubella _____
Hepatitis _____	Sinusitis _____	CMV*_____
High Fevers _____	Dizziness _____	Head Trauma_____
Mastoiditis _____	RSV*_____	TB*_____

*CMV – Cytomegalovirus *RSV – Respiratory Syncytial Virus * TB Tuberculosis

Has your child had frequent earaches or ear infections?
___ Yes ___ No
If yes, how many in the past 6 months? _____

Treatment used (i.e. antibiotics) _____

Surgery _____

Other _____

Comments_____

3. Please indicate whether this child has been diagnosed with a syndrome or other permanent medical condition: (check all that apply)

_____Allergies	_____Hyperactivity	_____Attention Deficit Disorder
_____Cancer	_____Impaired Vision	_____Immune Deficiency Disorder
_____Diabetes	_____Tinnitus (noise in ears)	_____Autism or Asperger's Syndrome
_____Kidney Disease	_____Cerebral Palsy	_____Cleft Palate
_____Seizures/Convulsions	_____Neurofibromatosis	_____Developmental Disability
_____Learning Disability	_____Emotional/Behavioral Disorder	

_____Other:
Please Describe:

_____

_____

_____

4. If the child has been hospitalized since birth, please describe the circumstances:

_____

_____

_____

_____

5. Please check any medications your child is on or has taken:

____ Vancomycin	____ Gentamycin	____ Lasix
____ Streptomycin	____ Chemotherapy	____ Radiation

____ Other:
_____

6. What medication is your child currently taking and for what reason?

_____

_____

_____

SPECIAL EDUCATION AND THERAPY

1. Please indicate any special education or therapy services this child has received: (check all that apply)

____Bilingual Education	____Occupational (OT)	____Physical (PT)
____Use of FM System	____Special Education	____Speech Language Therapy
____Social Services	____Reading Specialist	____Early Childhood Education
____Deaf Education	____Interpreting	____Teacher of the Hearing Impaired

____Other:_____

SPEECH AND LANGUAGE DEVELOPMENT

1. At approximately what age did this child:
Say his/her first word? _____
Speak in three word sentences? _____

2. How much of the child's speech can be understood?
By the family? _____ by others? _____

3. How does the child express his/her needs? (for example, ask for a drink):

_____

_____

_____

_____

4. Does this child use a system of communication other than speaking and listening?
(sign language, Cued Speech, a communication board, etc.) Yes No
If so, what type?
_____

HEARING ABILITY

1. Does your child have a hearing impairment? Yes No Not sure

2. Does he/she use hearing aids or a cochlear implant? Yes No

If so, what type? _____

(Please bring to appointment)

3. Does the child:

Consistently respond to sounds?	Yes	No
Turn toward loud sounds?	Yes	No
Look when his/her name is called?	Yes	No
Enjoy listening to music?	Yes	No

4. Please explain any concerns you have regarding the child's hearing.

_____

_____

_____

_____

5. Is there a history of hearing or speech problems during childhood in this child's family? Yes No

If so, please describe: _____

_____

_____

_____

_____

_____ _____

Signature of person completing case history Date

_____

Relationship to patient