HOW DID YOU HEAR ABOUT US?

Patient Name: _____

Television ☐ Doctor Referral ☐ Website/Online Search ☐

Phone Book ☐ Radio ☐ Newspaper ☐ Mailer ☐

Community Outreach ☐ Facebook ☐ Other ☐

Pediatric Audiological Case History

Child's Name: _____ **DOB**: _____ **Today's Date:**_____

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

HEARING

What is your primary concern today?

_____

_____

_____

How long have you noticed this problem? _____

What were the results of the child's newborn hearing screening?.....Pass Fail Unknown

Has your child had their hearing tested before?.....Yes No

If yes, where and when: _____

What were the results: _____

Is there any family history of hearing loss?.....Yes No

If yes, who: _____

When was their hearing loss identified:_____

Has your child received any medical treatment for their ears?.....Yes No

If yes, what was done:_____

When and where: _____

Do they complain of or exhibit any of the following in regards to their ear (circle as many as apply):

Pain Fullness Ringing Tugging on ear Clumsiness

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Birth History:

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

Child's weight at birth:_____

Please circle any of the following conditions below that occurred during or after pregnancy:

Caesarean	Lack of oxygen	Administration of oxygen to mother or child
Medication to child	In-utero infections	Jaundice
NICU care	Congenital defects	Alcohol consumption by mother
Chemotherapy	Head trauma	Low Apgar score

Speech-Language Development

Do you have any concerns with your child's speech development?.....Yes No

If yes, please describe:_____

_____

Is your child currently receiving speech therapy?.....Yes No

W*here*:_____

When did your child speak his / her first words?_____

Does your child understand what you say to him / her?.....Yes No

Are there any other concerns with your child's hearing, speech or balance that you would like to report?_____

_____

_____

_____

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