UNIVERSITY OF THE
PACIFIC

Pediatric Audiologic Case History

Date _____

Child's Name _____ D.O.B. _____

Parent/Guardian's Name: _____

Primary MD: _____ Referring MD: _____

GENERAL

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? _____

What were the results? _____

Do any of the child's relatives have hearing problems? ☐ Yes ☐ No

If yes: Who? _____ Age of identification? _____

PRENATAL HISTORY

Please check any of the conditions that occurred during pregnancy:

☐ HIV
☐ Alcohol abuse
☐ Substance abuse
☐ Cytomegalovirus (CMV)
☐ Maternal illness/infection
☐ Toxoplasmosis
☐ Gestational diabetes
☐ Preeclampsia
☐ Lack of oxygen
☐ Rubella
☐ Syphilis
☐ Herpes

Were there any additional pregnancy complications? _____

BIRTH HISTORY

Length of pregnancy _____ Child's weight at birth _____

Prolonged hospital stay? _____ Apgar scores _____

Please check if any were applicable during delivery/after birth:

☐ Emergency cesarean
☐ Mechanical ventilation
☐ Congenital anomalies
☐ Meningitis
☐ Other complications
☐ Oxygen administered
☐ Jaundice
☐ NICU stay
☐ Feeding tube
☐ Syndrome _____
☐ Phototherapy lights
☐ Aminoglycoside antibiotics
☐ Meconium aspiration

Please describe _____

_____

CHILD'S HEARING HISTORY

My child demonstrates the following auditory awareness. Please check all that apply:

☐ Startles to loud sounds
☐ Turns to speech/sound
☐ Quiets to speech/music
☐ Responds to "no"/name
☐ Awakens to loud sounds
☐ Follows directions

Has your child had a history of ear infections/ear drainage? ☐ Yes ☐ No

If yes, please describe _____

Has your child had medical/surgical treatment for his/her ears? ☐ Yes ☐ No

If yes, when? _____

Type of procedure _____

Does he/she ever complain of pain or fullness in the ears? ☐ Yes ☐ No

If yes, please describe _____

Has your child ever described noise in the ears? ☐ Yes ☐ No

If yes, please describe _____

Does your child fall or lose balance easily? ☐ Yes ☐ No

If yes, please describe _____

HEALTH HISTORY

Has your child experienced any of the following? If yes, please list date of occurrence:

☐ Measles	_____	☐ Tonsillitis	_____	☐ Chicken pox	_____
☐ Allergies	_____	☐ Mumps	_____	☐ Frequent colds	_____
☐ Scarlet Fever	_____	☐ Flu	_____	☐ Meningitis	_____
☐ Sinusitis	_____	☐ Encephalitis	_____	☐ High fevers	_____
☐ Seizures	_____	☐ Head injury	_____	☐ Blood transfusion	_____

Any other serious illness or surgery? ☐ Yes ☐ No

If yes, please describe _____

Does your child have any developmental delays? ☐ Yes ☐ No

Age sat without support _____

Age walked without support _____

Additional comments _____

Is your child currently receiving occupational or physical therapy? ☐ Yes ☐ No

If yes, where and how often? _____

Please list any medications as well as dosage and frequency (including non-prescriptions) your child is currently taking or has taken recently _____

_____

SPEECH-LANGUAGE DEVELOPMENT

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

_____

My child is using (check all that apply):

☐ Cooing	☐ Babbling	☐ Single words
☐ 1-2 word phrases	☐ 3 word sentences	☐ Full sentences

Age of your child's first word _____

How many words would you estimate your child uses? _____

How intelligible are his/her words? _____

If your child is not using words, how does he/she convey his/her wants and needs? _____

_____

Does your child follow directions? ☐ Yes ☐ No Comments _____

Does your child answer questions appropriately? ☐ Yes ☐ No Comments _____

Is your child currently receiving speech therapy services? ☐ Yes ☐ No Comments _____

Are there multiple languages spoken in the home? ☐ Yes ☐ No

If yes, what languages? _____

Additional comments or concerns: