

## 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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HIV                   | <input type="checkbox"/> Maternal illness/infection | <input type="checkbox"/> Lack of oxygen |
| <input type="checkbox"/> Alcohol abuse         | <input type="checkbox"/> Toxoplasmosis              | <input type="checkbox"/> Rubella        |
| <input type="checkbox"/> Substance abuse       | <input type="checkbox"/> Gestational diabetes       | <input type="checkbox"/> Syphilis       |
| <input type="checkbox"/> Cytomegalovirus (CMV) | <input type="checkbox"/> Preeclampsia               | <input type="checkbox"/> 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:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Emergency cesarean     | <input type="checkbox"/> Oxygen administered | <input type="checkbox"/> Phototherapy lights        |
| <input type="checkbox"/> Mechanical ventilation | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Aminoglycoside antibiotics |
| <input type="checkbox"/> Congenital anomalies   | <input type="checkbox"/> NICU stay           | <input type="checkbox"/> Meconium aspiration        |
| <input type="checkbox"/> Meningitis             | <input type="checkbox"/> Feeding tube        |   |
| <input type="checkbox"/> Other complications    | <input type="checkbox"/> Syndrome _____      |   |

Please describe \_\_\_\_\_

### CHILD'S HEARING HISTORY

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Startles to loud sounds | <input type="checkbox"/> Quiets to speech/music | <input type="checkbox"/> Awakens to loud sounds |
| <input type="checkbox"/> Turns to speech/sound   | <input type="checkbox"/> Responds to "no"/name  | <input type="checkbox"/> 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: