



Pediatric Audiology Case History

To be completed by a parent or guardian

IDENTIFYING INFORMATION:

Today's Date: _____

Client's Name (Please Print)

Last, First, MI: _____

Birthdate: ____/____/____ Age: ____ Biological Sex: Female: ____ Male: ____

Gender Identity: _____ Preferred Pronouns: _____

Primary care physician's name _____ Phone number _____

Child lives with: both parents Mother Father other

Name of Person Giving Information: _____ Relationship: _____

FAMILY INFORMATION:

Parent(s) or Guardian(s) Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Email(s): _____

Names and Ages of other children in the family:

The following questions are designed to help us evaluate your child's auditory system. Please answer them as accurately and completely as possible. If a question does not apply please write NA.

1. What is the primary reason for this appointment?

2. Do you feel your child's hearing is stable or does it fluctuate? _____



3. Has he/she been diagnosed with any medical conditions or developmental disabilities?

Yes _____ If yes, please list diagnoses _____

4. Does your child have a history of ear infections? Yes No

If yes, how many ear infections have they had? _____

5. Have tubes been placed in your child's ears or has your child had other ear surgeries?

Yes No

If yes, how many sets of tubes or what type of ear surgery? _____

6. To your knowledge did your child pass their newborn hearing screening? Yes

7. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age?

Yes

If yes, who in the family has a hearing loss and at what age? _____

8. Has your child's hearing been tested before by an audiologist? Yes No

If yes when was the last hearing test? _____ Where? _____

Results: _____

9. Does your child currently wear hearing aids? Yes

If yes, how old are the current aid(s)? _____

MEDICAL HISTORY:

Was any of the following present in your child's life? Please check all that apply

- | | |
|--|--|
| Measles | Infections at birth or in utero (e.g. CMV, herpes, rubella, syphilis, toxoplasmosis) |
| Meningitis | Postnatal infections associated with hearing loss (e.g. herpes, meningitis) |
| Mumps | Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome) |
| Allergies | |
| Neonatal intensive care for more than 5 days | |
| Hyperbilirubinemia (jaundice) | |
| Anoxia (oxygen deprivation) | |
| Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics) | |

ACADEMIC DEVELOPMENT:

1. Is your child in school? Yes Grade _____

2. How would you describe your child's academic performance/progress? _____

3. In what area is your child having difficulty? _____

4. Where is your child seated in the classroom? _____





