# 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? ____________________________

[redacted]

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

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? ______________________________

[redacted]

[redacted]