AMERICAN HEARING CENTER

Pediatric Case History

General Information

Today's Date: _____

Child's Name:_____ DOB:_____ Gender: ___Male ___ Female

Person completing form:_____ Relationship to child: _____

Mother's name:_____ Father's name:_____

Reason for Referral / Evaluation: _____

Educational Information (if applicable)

Grade: _____ School performance: ___ Above average ___ Average ___ Below average

Repeated a grade? _____No____Yes; If so, which grade(s)?_____

Does your child receive any special education services? ___No ___ Yes; What services?_____

_____

Hearing History

Results of newborn hearing screening (circle): Passed Referred None completed Unknown

Has your child been previously diagnosed with a hearing impairment? ___ No ___ Yes, at age _____

Does your child:

Consistently respond to sounds? __ No __ Yes Turn toward loud sounds? __ No __ Yes

Look when his/her name is called? __ No __ Yes

Has your child had frequent ear infections? __ No __ Yes If yes, how many in the past year? _____

Treatment used (i.e. antibiotics, tubes) _____

If applicable, date of last hearing evaluation _____

Does he/she use hearing aids or a cochlear implant? __ No __ Yes; make and model?_____

Please explain any concerns you have regarding your child's hearing:_____

_____

Is there a family history of hearing loss since childhood? If so, please list their relationship to your child:

_____

Medical/Developmental History

Please indicate if your child has a history of any of the following: ☐ None Apply

____ Premature birth
____ Problems before, during, or after birth
____ NICU stay
____ Low birth weight < 3.3 pounds
____ Hyperbilirubinemia/jaundice requiring exchange transfusion
____ Asphyxia or lack of oxygen at birth
____ Mechanical ventilation> 5 days
____ Required ECMO treatment
____ Head or neck abnormalities
____ Fetal alcohol syndrome
____ Syndromal abnormality
____ Known hearing problems
____ Frequent colds/allergies
____ Mastoiditis
____ Encephalitis
____ Serious illness or accidents
____ Head trauma
____ Fever over 104 degrees
____ Bacterial meningitis
____ Measles/Mumps/Rubella
____ Dizziness
____ Severe headaches
____ Ear pits/ear tags
____ Ear surgeries (tubes, etc.)
____ Delays in development (sitting, walking, talking)
____ Speech-language difficulties
____ Autism spectrum disorder
____Central Auditory Processing Disorder
____ Attention deficit hyperactivity disorder
____ Sensitive to loud sounds
____ Noise exposure
____Ototoxic medications (aminoglycosides/Chemotherapy/Loop diuretics)

If your child has experienced any of the above, please explain (include specific treatment and medications): _____

_____

_____

Please indicate if there was a history of any of the following during pregnancy:

____ German measles ____ Rubella ____ Toxoplasmosis ____ Herpes ____ Bad Fall ____ Cytomegalovirus
____ Syphilis ____ Car Accident ____ Kidney Infection ____ Drug use ____ HIV ____ Toxemia