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Lansdowne, VA 20176

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(703) 858-7657 (Fax)
www.speechhearing.org

# Pediatric Case History Form

*Audiology*

Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child's everyday level of functioning. Please try to give additional comments where appropriate.

**Please note*: If you wish for a report to be sent to the pediatrician, please be sure to provide their information.

Date completed: ___________________

**Child's Name: ______________________________________** (Nick name or goes by: ___________________)

**Child's Date of Birth:________________ Age: _____** **Sex: _____** **Grade in school: _____________**

Father's Name: ________________________________

Date of Birth:________________________________

Father's Address:_______________________

________________________________________

Father's Employer:_____________________

Position:______________________________

Father's Telephone: (H)_________________________

(W)_______________________________________

(C)_______________________________________

Email:_____________________________________

Mother's name: ___________________________

Date of Birth: _____________________________

Mother's Address: _________________________

__________________________________________

Mother's Employer: ________________________

Position: _________________________________

Mother's Telephone: (H) ___________________

(W) ______________________________

(C) ______________________________

Email: ____________________________

Parents' marital status: S M D W

Parents are remarried: Mother Father

Child Lives with: ☐ Birth Parents ☐ Foster Parents ☐ One Parent ☐ Adoptive Parents

☐ Parent and Step-parent ☐ Other: __________

Primary Language(s) spoken by **child**: _______________

Primary Language(s) spoken by **caregivers: _____________**

Other Languages spoken in home: __________

..........................................................................................................................................................

**Primary Insurance:** _________________________________ Phone: _________________________________

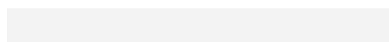
Address: ___________________________________________ ID#: ___________________________________

Card Holder Name: _________________________________ Card Holder DOB: _______________________

**Secondary Insurance:** _______________________________ Phone: _________________________________

Address: ___________________________________________ ID#: ___________________________________

Card Holder Name: __________________________________ Card Holder DOB: _______________________



## Statement of Problem

1. Reason for referral: ______________________________

1. When was the problem first noted: ______________________________
2. Has the child been seen elsewhere in regards to the problem? YES NO
   If so, when and what was suggested? ______________________________
3. What do you think caused the problem? ______________________________
   ______________________________
4. What difficulties has he / she experienced related to his /her hearing? ______________________________
   ______________________________
5. If you think he / she has a hearing loss, list the sounds that he / she seems to hear consistently: ______________
   ______________________________
6. Has he / she ever worn a hearing aid? YES NO

If yes, at what age were they fit with hearing aids? ______________________________

Make & Model: ______________________________

## Medical History

7. Was he / she premature? YES NO
   How many weeks premature? ______________________________
   How much did he / she weigh? ______________________________
8. What was his / her APGAR? ______________
9. Does he/she have:

| | Never | Rarely | Frequently | Date of Last Episode |
|---|---|---|---|---|
| Ear Aches | | | | |
| Ear Infections | | | | |
| How was it treated? | | | | |
| Draining Ears | | | | |
| Allergies | | | | |
| Sinusitis | | | | |
| Frequent Colds | | | | |
| Does it affect their hearing? | | | | |
| Fungal Infections (ears) | | | | |
| Excessive Ear Wax | | | | |
| Dizziness / Vertigo / Imbalance | | | | |
| Tinnitus / Ringing in ears/ Roaring in ears | | | | |
| Facial Numbness | | | | |
| Blurred Vision | | | | |
| Convulsions | | | | |
| Blackouts | | | | |
| Heart Problems | | | | |
| Strokes | | | | |
| Illnesses with High Fevers | | | | |

10. If he / she has had any of the previously listed disorders in the past year, please describe the nature of the illness, the treatment, and state whether it affected his/her hearing: ______________________________
______________________________________________________

11. Has he / she ever had ear surgery? YES NO
    If yes, when and what: ______________________________

## History of Pregnancy and Birth

12. List any illness that you had during your pregnancy: ______________________________
13. Were any medications taken during pregnancy? YES NO
    If yes, why were they taken? ______________________________
14. Where there any abnormalities of the child noted at birth? YES NO
    Describe: ______________________________
15. Did he/she pass the newborn hearing screening? YES NO
16. What hospital were they born at? ______________________________

## Developmental History

Was he/she slow in:

| | | | |
|---|---|---|---|
| Sitting unsupported | YES | NO | Acquired: ____________ |
| Creeping / Crawling | YES | NO | Acquired: ____________ |
| Walking | YES | NO | Acquired: ____________ |
| Self-feeding | YES | NO | Acquired: ____________ |
| Toilet training | YES | NO | Acquired: ____________ |

For what reason was he/she slow? ______________________________

17. Was there any problem with balance? YES No

## Speech History

18. When did the child babble normally? ________
19. Did he / she, at any time, stop babbling? YES NO
20. When did he / she begin to talk? _
21. Is his / her speech intelligible to people outside the family? ______________________________
22. Does he / she have any speech problems? ______________________________
    If yes, please describe: ______________________________

## Family History

23. Is there any history of hearing loss or deafness in the family?_______________Yes _______No
    If yes, please describe: ______________________________
24. How many children are in the family? ______________________________
25. Do any of your other children have speech or hearing problems? YES NO
    If yes, please describe: ______________________________

## Educational History

26. Is he/she in a special class? YES NO

    Specify: ______________________________

27. Does he/she receive any special services in school? YES NO

    Specify: ______________________________

28. Do any subjects cause particular difficulty? YES NO

    Specify: ______________________________

29. Does he/she like school? YES NO

30. Is his/her work satisfactory? YES NO

31. Additional comments: ______________________________

______________________________

Signature of Parent or Guardian

Statement of Release

Childs Name: ______________________ DOB: ______________________

I, ________________________________________
Parent or Guardian

hereby request and/or grant permission to the above named Clinic to send a report of the diagnostic findings for my child's, evaluation, and therapy progress of this case to the following:

Pediatrician: ______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________

ENT: ______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________

Audiologist: ______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________

Neurologist: ______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________

School: Loudoun County Public Schools
______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________

Patient: ______________________
Address: ______________________
______________________
Phone: ______________________
Fax: ______________________