Date: ____________________

PEDIATRIC CASE HISTORY

Child's Name: ____________________________Date of Birth:___________________

Parent(s)' Name(s): ____

Birth Hospital:____________________________ Pediatrician: ________________________________

Child's School:____________________Dist:____________Grade: ________________

Hearing History:
Are you concerned about your child's hearing? Why or why not?

Does your child have any known hearing loss? YES NO

Does your child have a history of middle ear infections? YES NO
If yes, when was the last one? _____________
If yes, what was the treatment? _______________________________

Did your child pass the newborn hearing screening at birth? YES NO N/A

Any family history of hearing problems in early childhood? YES NO

If yes, who and when were they diagnosed? ______________________

Is your child receiving any speech-language therapy services? YES NO
Are you concerned about your child's speech and language development? YES NO

Does your child have any associated disabilities? None Visual problems Cerebral palsy

Seizure disorder Down's Syndrome Developmental / Learning Disabilities Other:

Birth History:
Was your child born: Full-term Premature
If premature, how early? ______________ Birth weight _____________

Did your child experience any of the following:

On a ventilator for more than 7 days Asphyxia Breathing problems Hyperbilirubinemia Meningitis

Congenital malformations of the head, neck, or ears Treatment with intravenous antibiotics

Infections present at birth: None Herpes Syphillis Rubella
Cytomegaloviurs(CMV) Toxoplasmosis

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