Midwest Center for Hearing Excellence, LLC.

Pediatric Case History

Patient Name: ____
Birth date and place: ____
Address: ____
Phone: _________________________
Parent(s) Name: ________________

Who referred the child for a hearing evaluation?

Why was your child referred for a hearing evaluation?

Do you have concern for your child's hearing?

<u>Birth History</u>
Please answer the following with Y for yes and N for no.

Was your child born at full term?
Was your child delivered by Cesarean?
If yes, please indicate why.

Was your child in the Neonatal Intensive Care Unit (NICU)?
If yes, how long?

Was your child exposed to any of the following prior to, or at their birth?

Rubella ___ Measles___ Mumps___
Alcohol___ Drugs___ Nicotine___
Herpes___ Syphilis___ HIV___
Toxoplasmosis___ Meningitis___ CMV ___
Infection___

Did the mother have any illnesses or complications during pregnancy or at the child's birth?

Gestational diabetes___ Hypertension___ Renal disease___
Asthma___ Collagen disorders___ Other___

Did your child display any of the following at birth?

Jaundice___ Low birth weight___ Low Apgar scores___
Trauma or distress___ Birth defects___

Did your child receive any of the following after their birth?

Medication___ Ventilation___ other treatments ___

Was your child's hearing screened at birth? What were the results?

General Medical History

Does your child have a history of ear infections?
If yes, please indicate age of onset and how many.

Please list any other infections or medical conditions. Indicate how old your child was when they were detected.

Has your child been hospitalized since their birth?
If yes, please indicate reason.

Has your child had any surgeries?
If yes, please indicate type.

Has your child received any trauma to the head?
If yes, please describe.

Was your child breast fed?

Does your child have vision impairment?

Does your child have, or is there concern for, a syndrome?

Family History

Is there any family history of hearing loss?
If yes, please indicate family members.

Is there a family history of any syndromes?

Siblings	Age	Speech and Language Development	Medical Conditions

Developmental History
At what age did your child?

Sit up __________
Point_________
Say first word_______
Walk________
Speak two words together_______

Do you feel your child has a speech or language delay?

Do you feel you child plays appropriately with his/her peers?

Other
Does your child attend school or daycare?

Is your child having problems at school?

Do you have any educational concerns for your child?

Please indicate any other information that you feel may be important to the evaluation of your child's hearing.

Parent signature_________________________________ Date________________
Audiologist signature_____________________________ Date________________