Pediatric Case History Form

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_ Age\_\_­­­­\_\_ Date\_\_\_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

 Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician office’s name and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the child’s immediate family (blood relation) have permanent childhood hearing loss? \_\_\_\_\_\_\_\_\_\_\_

Patient’s Birth Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth weight \_\_\_ lbs.

**Check all that apply:**

Newborn hearing screening: Did not pass\_\_\_ missed screening \_\_\_ Pre-term Birth; how early? \_\_\_ Days in NICU \_\_\_ In-Utero infections (CMV, Herpes, Rubella) \_\_\_ Ototoxic med. at birth \_\_\_ Assisted Ventilation \_\_\_ Chemotherapy \_\_\_ Meningitis \_\_\_ Neurodegenerative disorder \_\_\_ Syndromes associated with hearing loss (ex: Usher, Alport) \_\_\_ Exchange transfusion for elevated bilirubin \_\_\_

Do you have any concerns about your child’s speech and language?

Does your child receive speech therapy? Where?

**Please check if your child has had any of the following:**

Ear pain \_\_\_ Ear infections (how many?) \_\_\_\_ Ear Surgery \_\_\_\_ Dizziness \_\_\_ Meningitis \_\_\_ Seizures \_\_\_ Measles­­ \_\_\_\_ Chicken pox \_\_\_ Mumps \_\_\_ Noise exposure \_\_\_\_ Autism spectrum disorder\_\_\_\_ Developmental delay \_\_\_ chronic illness; (if yes, explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have attention/ concentration difficulties?

Receive any special education services? Where?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s signature Relationship to patient Date