COLUMBUS SPEECH & HEARING CENTER
We Improve Communication for Life

Pediatric Case History

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Parent/Guardian: _____

Have you ever questioned your child's ability to hear normally? ☐ YES ☐ NO
If yes, please describe: _____

_____

How long have you noticed this problem? _____

Did your child pass their newborn hearing screening? ☐ YES ☐ NO

Has any other testing been completed since birth? ☐ YES ☐ NO
If yes: Where? _____ When? _____

Do any of the child's relatives have hearing problems? ☐ YES ☐ NO
If yes: Who? _____ What age was the loss identified? _____

Has your child been diagnosed with any of the following:

☐ Speech/language delays
☐ Hearing loss
☐ ADHD
☐ Autism/PDD
☐ Learning disabilities
☐ Dyslexia
☐ Movement disorder

Pre-Natal History

Please check any of the conditions that occurred during pregnancy:

☐ Rh incompatibility
☐ CMV
☐ Rubella/German measles
☐ Communicable diseases
☐ Substance abuse
☐ Lack of oxygen
☐ Infections
☐ Medication
☐ Alcohol abuse
☐ Maternal X-rays/illness
☐ Toxemia
☐ Venereal disease

Birth History

Age of mother at birth: _____ Length of pregnancy: _____

Child's weight at birth: _____ Birth hospital: _____

Please check any of the conditions that occurred during labor/delivery or hospital stay:

☐ Caesarean
☐ Medication given to child
☐ Jaundice
☐ Low APGAR scores
☐ Lack of oxygen
☐ Congenital defects
☐ Oxygen administered to mother/child
☐ Medication given to mother
☐ Special neonatal care of NICU
☐ Ventilator

If you checked any of the conditions above, please describe: _____

_____

510 E. North Broadway · Columbus · OH · 43214 · 614.263.5151
614.429.1382 VP · 614.263.2299 TTY · 614 263.5365 FAX
www.columbusspeech.org

Child's Hearing History

Has your child had recurrent middle ear infections? ☐ YES ☐ NO
If yes, what was treatment (i.e. antibiotics, PE tubes)? _____
At what age(s) did treatment occur? _____
Does he/she ever complain of pain or fullness in the ear? ☐ YES ☐ NO
Has your child ever described noise in the ear? ☐ YES ☐ NO
Which ear? ____ Right ____ Left
Has he/she ever been exposed to loud noises or an explosion? ☐ YES ☐ NO
Does your child fall or lose balance easily? ☐ YES ☐ NO
Describe: _____

Health History

Please check all that apply and **list date** of occurrence:

☐ Measles ____	☐ Concussion____	☐ Flu ____
☐ Allergies ____	☐ Skull Fracture ____	☐ Chicken pox ____
☐ Scarlet fever ____	☐ Tonsillitis ____	☐ Frequent colds ____
☐ Sinusitis ____	☐ Mumps ____	☐ Meningitis ____
☐ Seizures ____	☐ Ear infections ____	☐ Draining ears ____
	☐ Encephalitis ____	☐ High fevers ____

Any other serious illness or surgery? _____
Is he/she currently (or recently) under a physician's care? ☐ YES ☐ NO
List medications your child is currently taking: _____

Indicate any other evaluation or therapy your child has received (include dates):

Service	Provider
Speech	
Help Me Grow	
Physical Therapy	
Occupational Therapy	
Neurological	
Psychological	
Other	

When did he/she speak their first words? _____
Does your child understand what you say to him/her? ☐ YES ☐ NO

Is your child enrolled in a daycare or preschool? ☐ YES ☐ NO

Is there any other information you feel would be helpful for the audiologist to know?

_____

_____

Who can we thank for referring you to CSHC? _____

510 E. North Broadway · Columbus · OH · 43214 · 614.263.5151
614.429.1382 VP · 614.263.2299 TTY · 614 263.5365 FAX
www.columbusspeech.org