COLUMBUS SPEECH & HEARING
EST.1923

PEDIATRIC CASE HISTORY

Today's Date: _____ Child's Name: _____ DOB: _____

Parent/Guardian: _____ Parent/Guardian: _____

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

2. How long have you noticed this problem?
   _____

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

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

5. Do any of the child's relatives have hearing problems? ☐ YES ☐ NO
   If yes: Who? _____

6. 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

PRENATAL HISTORY

Please check any of the conditions that occurred during pregnancy:

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

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 in NICU ☐ Ventilator

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

CHILD'S HEARING HISTORY

1. Has your child had recurrent middle ear infections? ☐ YES ☐ NO
   If yes, what was the treatment (e.g., antibiotics, PE tubes)?

   _____

2. At what age(s) did the treatment occur?

   _____

3. Do they ever complain of pain or fullness in the ear? ☐ YES ☐ NO
4. Has your child ever described noise in the ear? ☐ YES ☐ NO
   Which ear? Right _____ Left _____
5. Have they ever been exposed to loud noises or an explosion? ☐ YES ☐ NO
6. Does your child fall or lose balance easily? ☐ YES ☐ NO
   Describe:

   _____

HEALTH HISTORY

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

☐ Measles ☐ Allergies ☐ Scarlet fever ☐ Sinusitis

☐ Seizures ☐ Concussion ☐ Skull fracture ☐ Tonsillitis

☐ Mumps ☐ Ear infections ☐ Encephalitis ☐ Flu

☐ Chicken pox ☐ Frequent colds ☐ Meningitis ☐ Draining ears

☐ High fevers

Any other serious illness or surgery?

Are they currently (or recently) under a physician's care? ☐ YES ☐ NO

List the 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		

1. When did they speak their first words?
2. Does your child understand what you say to them? ☐ YES ☐ NO
3. Is your child enrolled in a daycare or preschool?? ☐ YES ☐ NO
4. Is there any other information you feel would be helpful for the audiologist to know?
5. Whom can we thank for referring you to CSHC?