Pediatric Case History

Patient Information

Name: _____ Guardian: _____

Birthdate: _____ Gender: Male Female Other

Primary Language: _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: _____

Preferred Phone: Home Mobile Work

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

E-mail Address: _____ Work Phone: _____

Student Status: _____

Emergency Contact: _____Phone: _____Relationship: _____

Primary Care Physician: _____ Phone: _____

Child lives with: Both Parents Mother Father Other_____

Names and ages of any other children at home:_____

_____

Name and Address of Child's School, Preschool, or Child Care Setting: _____

_____

Reason for Visit

Chief Complaint: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both Dizziness/Vertigo

Auditory Processing Difficulties Failed Hearing Screening Other: _____

Medical History

Please circle if your child has had any of the following:

Allergies	Chicken Pox	Hospitalization	Mumps	Other: _____
Asthma	Ear Infections	Head Trauma/Injury	Noise Exposure (Headphones, Loud music, hunting, etc.)	
Balance/gait/dizziness problems	Ear/Nose/Throat Surgery	Kidney Problems		
Cerebral palsy	Eye/Vision Problems	Measle	Seizures	
		Meningitis		

Is the patient on any prescription or over-the-counter medications? No Yes

If yes, please provide list at check-in.

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Hearing History

Do you have any of the following concerns about your child's hearing? Select all that apply.

___ Does not respond to my voice

___ Does not react to loud noises

___ Does not search for or look towards where a sound is coming from

___ Does not seem to enjoy listening to music

___ Other: _____

Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?

No Yes If YES, who? _____

Has your child had a hearing test? No Yes

If Yes, please list by whom, when and results: _____

Does your child wear hearing aid(s)? No Yes

If Yes, when was your child first fit? _____

Does your child receive preferential classroom seating or other accommodations? No Yes

If Yes, briefly explain: _____

Risk Factors:

Were labor and delivery abnormal in any way? Select all that apply.

___ Labor Induced

___ Labor less than 3 hours

___ Labor longer than 24 hours

___ Premature membrane rupture

___ Bleeding

___ Forceps delivery

___ Cesarean Section (C-section)

___ Other _____

At what week of the pregnancy (gestation) was the child born? _____

Did the mother experience any of the following during the pregnancy? Select all that apply and briefly explain.

___ Drugs taken during (including antibiotics) _____

___ Exposed to chemicals _____

___ Exposure to radiation/chemotherapy _____

___ Amniocentesis performed

___ Rh immunoglobulin given (Rh or ABO incompatible)

___ Illnesses _____

___ Anemia

___ Diabetes

___ Toxemia

___ Paternal illnesses _____

___ None of the Above

Was the Mother exposed to any of the following diseases during the pregnancy: Select all that apply.

___ Chickenpox

___ Measles

___ Mumps

___ German Measles

___ Other _____

Was the Mother diagnosed with any of the following infections during the pregnancy? Select all that apply.

___ Syphilis

___ Herpes

___ Influenza

___ HIV/AIDS

___ Cytomegalovirus (CMV)

___ Toxoplasmosis

___ Other _____

Did the Mother take any medications during the pregnancy? No Yes

If yes, please provide list at check-in.

Newborn Factors:

After birth, did your child have any of the following issues. Select all that apply and briefly explain.

___Breathing difficulties

___Required an incubator

___Any head, neck, or ear abnormalities

___Feeding problems

___Surgery

___Any infections requiring medication

___Treatment for jaundice
(yellow coloration of the skin)

___ Birth weight less than 5 pounds
(specify birth weight) _____

___ Poor weight gain

___ Stayed in hospital after mother went home

___ APGAR score low at birth (list score) _____

___ Placed in intensive care (specify how long) _____

___ Oxygen given at birth (specify how long) _____

___ Bilirubin > 15mg/100ml

___ Congenital rubella

___ Physical deformities (specify) _____

___ High Fever

___ Defects of ear, nose, throat (specify) _____

___ Congenital heart disease

___ Septicemia

___ Drugs given (inc. antibiotics, specify) _____

___ Exposure to Chemicals (specify) _____

___ Paralysis at birth

___ Seizures at birth

___ Did not pass hearing screening

___Other _____

___None of the above

Please list all the ways you heard about us:_____

By signing below, I consent for my child to receive audiological services at All Generations Audiology, PLLC. The consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as my child receives audiological care at All Generations Audiology, PLLC.

Signature: _____ Date: _____

Relationship if not signed by patient (i.e. guardian, POA, etc.) _____