Child Case History—Audiology

Please fill out this form completely. Use NA for “not applicable,” CR for “can’t remember,” and DK for “don’t know.”

Child’s Name_________________________________________________ Date___________________________

Date of Birth ________________ Age__________ Sex________ Phone: Home_(_______)___________________

Parents _____________________________________________             Work_(_______)___________________

Address_____________________________________________________________________________________

City       State                        Zip

School ______________________________________________________ Grade _________________________

Referred by__________________________________

Chief complaint or reason for referral___________________________________________________________

1. Has your child had a previous hearing evaluation? yes_____ no______
   If so, when and what were the results?______________________________________________________

2. Do you think your child has hearing loss? yes_____ no______
   If so, in which ear? right______ left______ both________   When did it begin?_______________________
   What caused the hearing loss? ____________________________________________________________

3. Is there a family history of hearing loss? yes_____ no______
   If so, who had hearing loss?_______________________________________________________________
   What was the age it began?_______________ What caused the hearing loss?______________________

4. Are there any birth defects or abnormalities in other relatives? yes_____ no______
   If so, describe _________________________________________________________________________

5. Was the pregnancy and delivery with this child normal? yes_____ no______
   If not, what was the length of pregnancy? ______________________ What was birth weight? _________
   Describe maternal illnesses or complications _________________________________________________
   Describe problems at birth _______________________________________________________________

6. Has your child had ear infections? yes_____ no______
   If so, in which ear? right_____ left_____ both______ What age did they begin?____________________
   Has your child had drainage? yes_____ no______ How many infections has your child had? _________
   When was the last infection?_______________________________________________________________
   What kind of treatment has your child had? __________________________________________________

7. Has your child had surgery on his/her ears? yes_____ no______
   If so, which ear? right_____ left_____ both______
   What type of surgery did your child have? ___________________________________________________
   When and where was the surgery? _________________________________________________________

Please answer the questions on the reverse side of this form.
8. Check any listed diseases/symptoms your child has had.
   High fever _______________ frequent colds or sore throats ________________ allergies ________________
   Childhood diseases ________________ other ______________________________

9. What medications does your child currently take? _____________________________________________
   ___________________________________________________________________________________

10. What age did first words occur? ________________ What were first words? ________________
    When did sentences occur? ________________
    Check how your child communicates primarily now.
    Single words ________________ sentences ________________ gestures ________________

11. Do you understand most of what your child says? yes_____ no_____
    Do strangers understand your child? yes_____ no_____
    Do you think your child has a speech problem? yes_____ no_____

12. When did your child sit alone? ________________ When did your child crawl? ________________
    When did your child walk? ________________ Does your child seem well coordinated? yes_____ no_____

13. Does your child appear confused in noisy situations? yes_____ no_____
    Is your child easily distractable? yes_____ no_____
    Does your child have a short attention span? yes_____ no_____
    Does your child ask to have directions repeated? yes_____ no_____

14. Does your child like school? yes_____ no_____
    Has your child ever received special help at school? yes_____ no_____
    Has your child ever had behavioral problems at school? yes_____ no_____
    Have any teachers asked you to have your child’s hearing tested? yes_____ no_____
    Have any teachers asked you to have your child’s vision tested? yes_____ no_____
    Does your child seem to rely heavily on visual cues? yes_____ no_____

Additional comments:
______________________________________________
______________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature
______________________________________________
Relationship (if other than the patient)
______________________________________________

Please answer the questions on the reverse side of this form.