

Joplin Ear, Nose and Throat
Audiology
Pediatric Case History
(v.8/19)

Child's name _____ Nickname _____ DOB: _____

Person completing this form _____ Relation to child _____

Primary Care Physician _____ ENT (if any) _____

Reason for visit: _____

Please circle Yes or No for each question

HEARING HISTORY

Has your child's hearing been tested? YES NO

If yes, where? _____ When? _____

Results (if known): _____

Does your child wear a hearing aid? YES NO

If yes, please provide details: _____

Are there any family members with hearing loss? YES NO

If yes, please list relation: _____

Does your child have a history of ear infections/fluid? YES NO

If yes, when was the most recent occurrence? _____

Treatment: _____

COMMUNICATION/SOCIAL HISTORY

How does your child communicate (e.g. sentences, 1-2 words, sounds, gestures)?

How well is your child's speech understood by others? _____

- Has your child's speech and language been evaluated? YES NO
- If yes, explain: _____
- Has your child received speech or language therapy? _____
- Does your child tend to play alone or with other children? _____
- How does your child interact with other children/siblings? _____
- With adults? _____

HEALTH HISTORY

- Please list any complications during pregnancy (e.g. infections, high blood pressure, accident, alcohol/drug use, etc.) _____
- Please list any complications during birth (e.g. lack of oxygen, distress, trauma, etc.) _____
- _____
- Please list any health problems during the first 2 weeks of life (e.g. jaundice, breathing difficulty, infections, transfusion, medications, etc.) _____
- _____
- Please list any childhood illnesses and hospitalizations _____
- _____
- Please list any changes (past or present) that might have been stressful for your child (e.g. hospitalization, death of someone close, moving, separations/divorce, etc.) _____
- _____
- Please note any additional information related to today's visit _____
- _____

Parent/Guardian Signature: _____ Date: _____