

DuPage Medical Group – Audiology Department

PEDIATRIC CASE HISTORY

Child's Name: _____ D.O.B.: _____ Grade: _____
Referring Physician: _____ Mother's Name: _____
Concern: _____ Father's Name: _____

Otological History:

1. Has your child experienced any ear infections? Yes No
If yes, how frequently? _____
When was the most recent infection? _____ Treatment? _____

2. Has your child ever been seen by an ENT (ear, nose & throat) physician? Yes No
If yes, physician name: _____ When: _____

Concern at the time: _____

3. Has your child ever had ear surgery? Yes No
If yes, describe: _____

4. Has your child ever had a diagnostic hearing test in the past? Yes No
If yes, when? _____ Results? _____

5. Did your child pass a hearing screening in the hospital when born? Yes No

Please check (√) if your child has experienced any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Hears noises in the ears | <input type="checkbox"/> Drainage from the ear | <input type="checkbox"/> Balance difficulties |
| <input type="checkbox"/> Often asks for repetition | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Wax accumulation |
| <input type="checkbox"/> Swimmers ear | <input type="checkbox"/> Failed hearing screening | <input type="checkbox"/> Speaks loudly |
| <input type="checkbox"/> Sensitive to loud noises | <input type="checkbox"/> Difficulty with directions | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Difficulty following stories | <input type="checkbox"/> Academic difficulty |
| <input type="checkbox"/> Diagnosed ADD/ADHD | <input type="checkbox"/> "Hears but does not listen" | |
| <input type="checkbox"/> Known behavioral problems | | |

(OVER →)

