DuPage Medical Group – Audiology Department

PEDIATRIC CASE HISTORY

Patient Label Here

Child's Name: _____
DOB: _____ Grade: _____

Mother's Name: _____
Father's Name: _____

Referring Physician: _____
Primary Concern: _____
_____

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:

- ○ Academic difficulty
- ○ Often asks for repetition
- ○ Hyperactivity
- ○ Sensitive to loud noises
- ○ Short attention span
- ○ Diagnosed ADD/ADHD
- ○ Known behavioral problems
- ○ Difficulty with directions
- ○ Difficulty following stories
- ○ "Hears but does not listen"
- ○ Speaks loudly
- ○ Drainage from ear
- ○ Ear pain
- ○ Swimmer's ear
- ○ Wax accumulation
- ○ Balance difficulty
- ○ Hears noises in the ears
- ○ Failed hearing screening

(OVER →)

Developmental History:

1. Were there any complications during either birth or pregnancy? Yes No
   If yes, describe: _____

2. Was your child born prematurely? Yes No
   If yes, how many weeks? _____ Birth weight: _____
   If known, what were your child's APGAR scores? _____

3. Are there any known genetic disorders within the child's family? Yes No
   If yes, describe: _____

4. Do you have any concerns regarding your child's speech and language development? Yes No
   If yes, describe: _____

   Has your child been evaluated yet for this concern? Yes No
   Is your child receiving speech therapy? Yes No

5. Does your child have any other developmental difficulties? Yes No
   If yes, please describe: _____

General Medical History:

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

○ Hyperbilirubinemia	○ Asphyxia	○ Congenital Infections
○ Bacterial Meningitis	○ Mechanical Ventilation	○ Fetal Alcohol Syndrome
○ Fever over 104°	○ Kidney problems	○ Heart problems
○ Head/Neck abnormalities	○ Seizures	○ Blood transfusion
○ Maternal substance abuse	○ Environmental allergies	○ Chemotherapy
○ Radiation	○ Other serious illness or accident	

→ _____ _____
Signature of person completing history Date

→ _____
Relationship to child