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PEDIATRIC CASE HISTORY

Name: _____ Date: _____

1. What is the **primary** purpose of today's visit?

- Hearing Concerns Speech/language concerns
- Newborn hearing screening Other: _____

2. Do you suspect that your child has **hearing difficulties**?

- Yes If so, please describe concerns: _____
- No

3. Is there any **family history** of hearing problems?

- Yes If so, please describe: _____
- No

4. Has your child recently experienced any of the following?

- Sudden change in hearing Ear pain
- Ear infection Ear pressure/fullness
- Ear drainage Other: _____

5. Has your child been treated for any **medical issues involving his/her ear(s)**?

- Yes If so, please describe: _____
- No

6. Does your child have any **significant health problems**?

- Yes If so, please describe: _____
- No

7. Does your child have any **speech and/or language problems**?

- Yes If so, please describe: _____
- No

8. Did your child pass his/her **newborn hearing screening**?

- Yes
- No

9. Did your child spend any time in the **NICU**?

- Yes If so, please describe: _____
- No

10. Were there any **complications at birth**?

- Yes If so, please describe: _____
- No

Additional Comments: _____