

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: _____