Heard It Through The Grapevine Audiology, PC

PEDIATRIC CASE HISTORY

PATIENT INFORMATION

Child's name: _____ Age: _____

Date of Birth: _____ Date: _____

What is the primary reason you are getting your child's hearing tested?

_____

FAMILY HISTORY

Family history of hearing loss YES NO

If yes, who? _____ Age loss identified: _____

Is there a family history of any of the following medical conditions:

- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Progressive Blindness
- ☐ History stillbirths/miscarriages
- ☐ Other children with hearing loss

INFANT / CHILDHOOD FACTORS

Eye problems YES NO If yes, specify: _____

Balance/gait/dizziness problems YES NO Cerebral palsy YES NO

Seizures YES NO Head/skull injury YES NO

Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No

If so, please mark all that apply:

- ☐ Farm Machinery
- ☐ Music
- ☐ Hunting/Shooting
- ☐ Factory Noise
- ☐ Power Tools
- ☐ Military
- ☐ Jet Engines
- ☐ Other:_____

CHILD EVER HOSPITALIZED FOR / DIAGNOSED WITH / TREATED FOR:

- ☐ Meningitis
- ☐ Encephalitis
- ☐ Measles
- ☐ Influenza
- ☐ Cytomegalovirus (CMV)
- ☐ Chickenpox
- ☐ Septicemia
- ☐ Diabetes
- ☐ Sickle Cell
- ☐ Rubella
- ☐ ADHD/ADD
- ☐ Learning Disability
- ☐ Auditory Processing Disorder
- ☐ Cancer
- ☐ Speech and/or Language Disorder

Please list any other hospitalizations and/or surgeries _____

_____

HISTORY OF EAR PROBLEMS

Ear infections: NONE LEFT RIGHT BOTH If yes, specify what ages, how many and how often:

_____

When was last ear infection: _____

Ever had "tubes" in ears? NONE LEFT RIGHT BOTH If yes, specify when & how many times:

_____

Has your child's hearing been tested before? YES NO If yes, specify when & where: _____

_____

Did your child pass his/her newborn hearing screening? YES NO

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Does your child have an ENT physician? _____

MEDICATIONS

Does your child take any prescription medications on a regular basis? Please list?

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

DOCTORS (SPECIALISTS)

Please list other doctors and/or specialists that treat your child:

_____

_____

_____

_____

ACADEMIC PROGRESS

What grade is your child in at school? _____

Do you have any concerns for academic performance? _____

Is any other testing being conducted through the school? _____