Pediatric Case History Form

(ages 0-12 years) **Today's Date: _____**

Patient Name_____ Birth date_____ Age_____

Referred by? _____

Reason for today's visit: _____

Did your child have a newborn hearing screening? Yes No

If so, what were the results? _____

Are you concerned about your child's speech/language development? Yes No

If so, please explain: _____

Is your child enrolled in any therapies or interventions? Yes No

If so, please explain: _____

Has your child had a hearing test before? Yes No

Is there a family history of childhood hearing loss? Yes No

If Yes, Who? _____

Has your child ever had ear infections? Yes No

If yes, how many and date of most recent infection? _____

Has your child ever had ear surgery? Yes No

If yes, please explain: _____

Please check all that apply:

___Premature birth ___Oxygen required at birth ___Low birth weight (under 5 lbs)

___Failed newborn hearing test ___Developmental delay ___Pediatric intensive care at birth

___Complications during pregnancy ___Wears hearing aids

___Chronic illness or genetic disorders (please explain) _____

Any additional comment of information that you would like us to know: _____

_____

_____

_____

_____

Please list any medications taken on a regular basis **on back of form**. →

Signature of parent or guardian_____ Date_____

Patient Medication Information

Name:_____ DOB: _____ DATE:_____

Please list all medications below.

(Including Over the Counter/Vitamins/Herbal Supplements)

Medication	Dosage/Strength	Frequency	Route of administration (oral, injection, etc.)

Reviewed by: Clinician Date

_____ _____

_____ _____

_____ _____