Clear Fields

REM Audiology Associates P.C.

PEDIATRIC CASE HISTORY

Patient Name: _____
Date: _____ **Referral Source:** _____
Date of Birth: _____ **Age:** _____ **Gender:** ☐M ☐F

Child lives with: ☐both parents ☐mother ☐father ☐other
Names and ages of any other children at home: _____
Name/Address of Child's School, Preschool or Child Care Setting:_____

HEARING HISTORY:	**YES**	**NO**
Do you have any concerns about your child's hearing?	☐	☐
If yes, briefly explain:_____		
Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?	☐	☐
If yes, please explain:_____		
Does your child consistently respond to your voice?	☐	☐
Does your child respond to loud noises?	☐	☐
When sound is present or someone is speaking, does your child search to find where the sound is coming from?	☐	☐
Does your child respond to sounds from other rooms?	☐	☐
Has your child's hearing ever been tested?	☐	☐
If yes, please list by whom, when and results:_____		
Does your child wear hearing aid(s)?	☐	☐
If yes, when was your child first fit? _____		
Does your child use an FM System/auditory trainer?	☐	☐
Does your child receive preferential classroom seating?	☐	☐

PREGNANCY AND BIRTH HISTORY	**YES**	**NO**
Were there any complications during pregnancy?	☐	☐
Were there any complications during delivery?	☐	☐
Was the child born full term?	☐	☐

	YES	NO
Did the mother have any illness during the pregnancy?	☐	☐
Did the mother take any medication during the pregnancy?	☐	☐
After birth, did your child have:		
Extra hospitalization?	☐	☐
Breathing difficulties?	☐	☐
Require an incubator?	☐	☐
Any head, neck or ear abnormalities?	☐	☐
Feeding problems?	☐	☐
Surgery?	☐	☐
Any infections requiring medication?	☐	☐
Treatment for jaundice (yellow coloration of the skin)?	☐	☐

If yes to any above, briefly explain:_____

Did your child pass his/her Newborn Hearing Screening?	☐	☐

MEDICAL HISTORY

	YES	NO
Do you have any medical concerns about your child?	☐	☐

If yes, briefly explain:_____

Please check if your child has had any of the following:

Ear infections (how many) _____	Meningitis ☐	Seizures ☐	Ear surgery ☐
Measles ☐	Kidney problems ☐	Hospitalization ☐	Mumps ☐
Vision problems ☐	Head trauma/injury ☐	Allergies ☐	Asthma ☐
Noise exposure (e.g. farm equipment, loud music) ☐		Frequent colds/Sinus infections ☐	

Briefly explain any you checked:_____

Other significant medical concerns:_____

_____

Please list any prescription or over-the-counter medications your child is taking and for what reason(s):_____

PHYSICAL DEVELOPMENTAL HISTORY

	YES	NO
Do you have any concerns about your child's physical development?	☐	☐

If yes, briefly explain:_____

About what age did your child:
- hold his/her head erect_____
- sit unsupported_____
- crawl_____
- walk alone_____

Does he/she lose their balance or fall easily?	☐	☐
Does he/she seem uncoordinated or clumsy?	☐	☐

SPEECH AND LANGUAGE HISTORY

	YES	NO
Do you have any concerns about your child's speech and language?	☐	☐

If yes, briefly explain:_____

About what age did your child:
- follow simple directions _____
- say his/her first word _____

put two words together _____

Did your child continue adding words after the first word? ☐ ☐

If your child is 2 years old or younger, how many words does he/she use? _____

Does your child often use gestures when communicating? ☐ ☐

Is your child's speech understood by: Parents? ☐ ☐

Siblings? ☐ ☐

Other Adults? ☐ ☐

Has your child's speech ever been evaluated? ☐ ☐

If yes, please list by whom, when and results:_____

Is your child currently receiving speech therapy? ☐ ☐

ADDITIONAL HISTORY **YES** **NO**

Do you have any other concerns about your child? ☐ ☐

If yes, briefly explain:_____

Does your child:

play/interact well with other children? ☐ ☐

have attention/concentration difficulties? ☐ ☐

receive any special education services? ☐ ☐

If yes to any of the above, briefly explain:

Do you feel that your child is having any difficulty in school? ☐ ☐

If yes, briefly explain:_____

Additional Comments/Concerns: _____

_____

_____

_____

_____

_____

_____

_____

Name of person completing this form: _____

Relationship to Patient: _____