

PEDIATRIC CASE HISTORY
(For Children Ages 6 months to 4 years)

Child's full name: _____ Date of birth: _____
 Mother's full name: _____ Child's sex: Female Male
 Father's full name: _____
 Legal guardian's full name: _____
 Person completing this form: _____
 Please describe the reason for the child's visit to the office: _____

PREGNANCY & BIRTH HISTORY

Length of pregnancy: _____ weeks Birth weight: _____ lbs. _____ oz.
 Hospital of delivery: _____
 Type of delivery: _____ Was labor induced? Yes No
 Did the child spend any time in the NICU? Yes No If so, how long? _____
 Any complications during pregnancy or delivery? Yes No If so, please explain? _____

What was the child's Apgar score? 1 2 3 4 5 6 7 8 9 10

Did any of the following occur during pregnancy? (please check all that apply)

_____ German measles _____ Rubella _____ Toxoplasmosis
 _____ Cytomegalovirus (CMV) _____ Herpes _____ Drinking/drug use
 _____ Syphilis _____ Smoking _____ Kidney infection

MEDICATIONS Please list all medications, vitamins, or drugs taken during pregnancy and delivery

Name of medication	What is the medication taken for?

Is the child currently taking any of the following medications? (please check any/all that apply)

_____ Vancomycin _____ Gentamycin _____ Radiation _____ Streptomycin
 _____ Chemotherapy _____ Other: _____

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Known risk factors (please check all that apply)

- Family history of hearing loss CHARGE syndrome
 Head trauma requiring hospitalization Pulmonary hypertension
 Confirmed bacterial meningitis Trisomy 21 (Down syndrome)
 Hyperbilirubinemia/jaundice (requiring exchange transfusion)
 Anatomic malformation of head, face, or neck (e.g., dysmorphic appearance, cleft lip or palate, abnormalities of ear such as microtia, atresia, or periauricular tags/pits)
 Other conditions/diagnoses: _____

Does the child have siblings? Yes No
If yes, please list all siblings and their ages _____

Has the child had a fever greater than 104° F? Yes No
If yes, at what age and how long did the high fever last? _____
Has the child ever been hospitalized? Yes No
If yes, what procedures/treatments were performed? _____

Has the child ever been seen by a specialist of physician other than the pediatrician? Yes No
Who? _____ When? _____
Reason? _____
Outcome? _____

DEVELOPMENTAL MILESTONE

Do you have concerns regarding the child's hearing? Yes No
If yes, please explain, including when this was first noticed: _____

What were the results of your child's Universal Newborn Hearing Screening?

- Passed both ears Referred left ear only
 Referred both ears Referred right ear only

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Does the child...	Consistently respond to sounds?	Yes	No	Respond to his/her name?	Yes	No
	Turn to find a sound source?	Yes	No	Enjoy listening to music?	Yes	No
	Startle to loud noise?	Yes	No			

How many ear infections has the child had? _____ When was the last infection? _____
 How is it/are they treated? _____
 Has your child ever had tubes placed in his/her ears? _____

How does the child communicate with others? _____
 (e.g. spoken English, spoken Spanish, ASL, cued speech, total communication, etc.)

At approximately what age did the child:
 Say his/her first word? _____ Yrs. _____ Mos.
 Speak in three word sentences? _____ Yrs. _____ Mos.

How much of the child's speech can be understood?
 By the family? Yes No Sometimes Explain: _____
 By others? Yes No Sometimes Explain: _____

Do you have concerns regarding your child's speech/language development? Yes No
 If yes, please explain: _____

Does the child receive speech/language services or therapy? Yes No
 If yes, where? _____ From whom? _____
 How often? _____ times per week Appointment length: _____ minutes

At approximately what age did the child:
 Hold his/her head erect: _____ Yrs. _____ Mos.
 Sit unsupported: _____ Yrs. _____ Mos.
 Walk alone: _____ Yrs. _____ Mos.

Do you have concerns regarding the child's physical development or balance? Yes No
 If yes, please explain: _____

Does the child receive physical therapy? Yes No
 If yes, where? _____ From whom? _____
 How often? _____ times per week Appointment Length: _____ minutes

Does the child attend Day Care/Preschool? Yes No
 Where? _____
 How often? _____



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Updated 03/2018

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Please explain any other pertinent information that you would like the audiologist to know:

A series of 25 horizontal lines provided for entering information.