

**CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
AUDIOLOGY PEDIATRIC CASE HISTORY**

Child's Name: _____ Date: _____

Primary Care Physician: _____

Mother's Name: _____ Occupation: _____

Maiden Name: _____

Father's Name: _____ Occupation: _____

Legal Guardian Name: _____

Reason for today's appointment: _____

Did your child have a Newborn Hearing Screen at birth? ____ Yes ____ No

What hospital was the child born in? _____

What were the results?: _____

Describe any problems or complications with mother's pregnancy or child's birth: _____

Has the child received any prior hearing testing? ____ Yes ____ No

If yes, where? _____

Does the child require hearing aids or assistive listening devices? ____ Yes ____ No

If yes, please describe: _____

Are there other children in the family? ____ Yes ____ No Ages: _____

Are you concerned about the child's hearing? ____ Yes ____ No

If yes, what are your concerns? _____

Does the child have frequent ear infections? ____ Yes ____ No

If yes, how often? _____

How have the ear infections been treated? _____

Does the child receive Early Intervention or Special Education Services? ____ Yes ____ No

If yes, what kind of services? _____

Please describe any serious illness or medical problems the child has: _____

Does anyone on the mother's or father's side of the family have hearing loss starting at infancy or childhood? ____ Yes ____ No

If yes, who? _____

Are there any resources that you would like to our audiologist to assist you with? _____

Provide names and addresses of anyone you would like us to send a report to:

This form completed by:

Name: _____ Date: _____

Relationship: _____