

PEDIATRIC CASE HISTORY
(For Children Ages 5 through 18 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: _____

Any complications during pregnancy or delivery? Yes No If so, please explain. _____

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

| Name of medication | What was the medication taken for? |
|--------------------|------------------------------------|
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Is the child currently taking any of the following medications? (please check all that apply)

Vancomycin Gentamycin Radiation
 Chemotherapy Other: _____

MEDICATIONS Please list all the child's ***current medications and vitamins***

| Name of medication | What is the medication taken for? |
|--------------------|-----------------------------------|
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Known risk factors (please check all that apply)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Family history of hearing loss | <input type="checkbox"/> CHARGE syndrome |
| <input type="checkbox"/> Head trauma requiring hospitalization | <input type="checkbox"/> Pulmonary hypertension |
| <input type="checkbox"/> Confirmed bacterial meningitis | <input type="checkbox"/> Trisomy 21 (Down syndrome) |
| <input type="checkbox"/> Hyperbilirubinemia/jaundice (requiring exchange transfusion) | |
| <input type="checkbox"/> 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) | |
| <input type="checkbox"/> 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? _____

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

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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

When was the child's last hearing evaluation? _____

What were the results? _____

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

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

Are there any concerns for and/or diagnoses of Attention Deficit Disorders?

If yes, please explain: _____

