WARRIOR HEARING CENTER

PEDIATRIC AUDIOLOGY CASE HISTORY

To be completed by a parent or guardian

Date: _____

Client's Name (Please Print) _____
First Name Middle Initial Last Name

Birthdate: (month day year) _____ / _____ / _____ Age: _____

Gender: ☐ Female ☐ Male

Primary care physician's name _____ Phone number _____

Child lives with: ☐ both parents ☐ Mother ☐ Father ☐ Other _____

Referred by _____

Name of Person Giving Information _____ Relationship: _____

FAMILY INFORMATION

Parent(s) or Guardian(s) Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Email(s): _____

Names and Ages of other children in the family:

_____

_____

_____

_____

The following questions are designed to help us evaluate your child's auditory system. Please answer them as accurately and completely as possible. If a question does not apply, please write NA.

1. What is the primary reason for this appointment? _____

_____

_____

2. Do you feel your child's hearing is stable or does it fluctuate? _____

_____

_____

1103 S US-169, Suite F, Smithville, MO 64089
816-592-3575 ▲ warriorhearing.com

3. Has he/she been diagnosed with any medical conditions or developmental disabilities?

   ☐ Yes ☐ No If yes, please list diagnoses

4. Does your child have a history of ear infections? ☐ Yes ☐ No

   If yes, how many ear infections have they had? _____

   _____

   _____

5. Have tubes been placed in your child's ears or has your child had other ear surgeries? ☐ Yes ☐ No

   If yes, how many sets of tubes or what type of ear surgery? _____

6. To your knowledge did your child pass their newborn hearing screening? ☐ Yes ☐ No

7. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age? ☐ Yes ☐ No

   If yes, who in the family has a hearing loss and at what age? _____

8. Has your child's hearing been tested before by an audiologist? ☐ Yes ☐ No

   If yes when was the last hearing test? Where? Results: _____

9. Does your child currently wear hearing aids? ☐ Yes ☐ No

   If yes, how old are the current aid(s)? _____

MEDICAL HISTORY

Was any of the following present in your child's life? Please check all that apply

- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Allergies
- ☐ Neonatal intensive care for more than five days
- ☐ Hyperbilirubinemia (jaundice)
- ☐ Anoxia (oxygen deprivation)
- ☐ Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics)
- ☐ Infections at birth or in utero (e.g. CMV, herpes, rubella, syphilis, taxoplasmosis)
- ☐ Postnatal infections associated with hearing loss (e.g. herpes, meningitis)
- ☐ Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome)

ACADEMIC DEVELOPMENT

1. Is your child in school? ☐ Yes ☐ No Grade _____

2. How would you describe your child's academic performance/progress? _____

3. In what area is your child having difficulty? _____

4. Where is your child seated in the classroom? _____

5. Does your child currently receive support services (including speech language therapy, occupational therapy, physical therapy, special education)? ☐ Yes ☐ No

   If yes please explain type of services _____

6. Does your child seem to have any of the following issues? Please check all that apply.

   ☐ Problems following directions

   ☐ Distracted by background noise

   ☐ Oral and written expression problems

   ☐ Remembering what they hear

   ☐ Difficulty with multistep directions

   ☐ Learning to read