**PEDIATRIC CASE HISTORY**

Patient Name: Age: Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy and Birth History With This Child**

Hospital of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illness or Complications during Pregnancy: YES NO

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If in the NICU, how many days/weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After Birth, did this child have any of the following:**

□ Jaundice □ Blood Transfusion □ Breathing Problems

□ Require Diuretics □ Require IV Antibiotics □ Require Mechanical Ventilation

**Childhood Medical History**

**Please check any that may apply:**

**□** Concern re: Hearing Loss **□** Speech and Language Concern **□** Seizure Disorder

**□** Ear Infections **□** ADD/ADHD or Learning Disability **□** Vision Problems

**□** Hole or Perforated Eardrum **□** Family History of Hearing Loss **□** Head Injury

**□** Excessive Ear Wax **□** Hole or Perforated Eardrum **□** Tubes in Ear

**□** Fluid Behind Ear Drum **□** Ear Canal Drainage **□** Ear Pain or Discomfort

**□** MRSA (Resistant Staph Infection) **□** Cleft Palate and/or Cleft Lip

**Has this child ever been seen by an Ear, Nose and Throat Specialist?** **YES NO**

If Yes, Dr Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When/Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVER**

**PEDIATRIC CASE HISTORY cont.**   
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**Has this child been diagnosed with any illness or syndrome? YES NO**

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any abnormalities of the face, head, skin, muscles, bones, kidneys, heart, eyes, or other body system? YES NO**

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does this child have any allergies or medical reactions? YES NO**

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has this child had any surgeries or hospitalizations? YES NO**

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has this child ever failed a hearing screen?** **YES NO** When/Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does this child smoke?** **YES NO** **Have exposure to secondhand smoke?**  **YES NO**

**Does this child take any medications on a regular basis? Please list below or we can copy a list if you have it with you:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please tell us anything else you have concerns about with this child’s hearing:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Reviewed and Updated:**

\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Initial Date Initial Date Initial Date Initial Date

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Initial Date Initial Date Initial Date Initial Date