



# Salem Audiology Clinic, Inc.

3857 - 16C Wolverine Street NE, Salem, OR 97305 (503) 588-1039  
2200 Country Club Court, Suite E, Woodburn, OR 97071 (503) 981-8575  
www.salemaudiologyclinic.com

## PEDIATRIC CASE HISTORY

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Names: \_\_\_\_\_ Guardian SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Guardian Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Child's Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

\*\* All contact information will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Your initials: \_\_\_\_\_

What is your main concern or reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_

### CHILD'S HEARING HISTORY

(Please circle appropriate answer and provide further information where necessary.)

Did your child pass his/her newborn hearing screening? Yes No  
If no, which ear or both? \_\_\_\_\_  
Any previous hearing tests? Yes No  
If yes, where and what were the results? \_\_\_\_\_

### MOTHER'S PREGNANCY HISTORY FOR THIS CHILD

Length of pregnancy: \_\_\_\_\_ Drug/alcohol use (specify): \_\_\_\_\_  
Infections (Rubella, CMV, Herpes, Toxoplasmosis)? \_\_\_\_\_  
Medications (specify): \_\_\_\_\_ Any complications? \_\_\_\_\_

### CHILD'S BIRTH HISTORY

Normal with no complications? Yes No If no, specify complications: \_\_\_\_\_  
Low birthweight (below 3.3 pounds/1500 grams)? Yes No  
Breathing problems? Yes No (specify) \_\_\_\_\_  
Jaundice requiring blood transfusion? Yes No \_\_\_\_\_  
Birth defects? Yes No (specify) \_\_\_\_\_

### CHILD'S MEDICAL HISTORY

Family history of hearing loss? Yes No If yes, who? \_\_\_\_\_  
Has your child had any ear infections? Yes No If yes, most recent: \_\_\_\_\_  
Has your child had any ear surgery (PE tubes, etc.)? Yes No (specify) \_\_\_\_\_  
Medical problems? Yes No (specify) \_\_\_\_\_  
Balance problems? Yes No (specify) \_\_\_\_\_

Please describe your child's responsiveness to sound: \_\_\_\_\_  
Any speech or language concerns? Yes No (specify) \_\_\_\_\_  
Any educational concerns or problems? Yes No (specify) \_\_\_\_\_  
Name of school: \_\_\_\_\_

Other significant information: \_\_\_\_\_  
\_\_\_\_\_