



Salem Audiology Clinic, Inc.

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www.salemaudiologyclinic.com

PEDIATRIC CASE HISTORY

Child's Name: _____ Date of Birth: _____ Date: _____

Child's Physician: _____ Clinic: _____

**** 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? _____
Insurance: _____

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: _____