

Pediatric Case History

Name: _____ Date: _____

Referring Physician: _____

Form Completed by: _____

DEVELOPMENTAL HISTORY:

1. Were there complications during the pregnancy? Yes No
If yes, describe: _____
2. Were there complications during the birth? Yes No
If yes, describe: _____
3. Did your child have a premature birth? Yes No
If yes, how many weeks? _____
What was your child's APGAR score? _____
What was your child's birth weight? _____
4. Has your child had any serious illness or accidents? Yes No
If yes, describe: _____

Please check (√) if your child had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Fetal alcohol syndrome | <input type="checkbox"/> Ototoxic medication | <input type="checkbox"/> Asphyxia |
| <input type="checkbox"/> Hyperbilirubinemia | <input type="checkbox"/> Mechanical Ventilation | <input type="checkbox"/> Head/neck deformity |
| <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Fever over 104 ° F | <input type="checkbox"/> Craniofacial abnormalities |
| <input type="checkbox"/> Congenital Perinatal infections | <input type="checkbox"/> Maternal substance abuse | <input type="checkbox"/> Syndromal abnormality |

OTOLOGIC HISTORY:

Has your child experienced any of the following? Please check (√) all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Ear canal discharge |
| <input type="checkbox"/> Excessive ear wax | <input type="checkbox"/> Tubes in the ear | <input type="checkbox"/> Hole/perforated eardrum |
| <input type="checkbox"/> Fluids behind the eardrum | <input type="checkbox"/> Soreness/pain in the ear | <input type="checkbox"/> Other: _____ |

1. Has your child had an ear infection in the last 6 months? Yes No
If yes, when was the last episode? _____
Was medication prescribed? Yes No If yes, which medication? _____
2. Is there a family history of ear problems? Yes No
If yes, who? _____
What type? _____
Was medication prescribed? Yes No If yes, which medication? _____

3. Has your child ever been treated by an Ear, Nose & Throat (ENT) doctor? Yes No
 If yes, who? _____
 When? For What? _____
 Was medication prescribed? Yes No If yes, which medication? _____
4. Has your child ever had ear surgery? Yes No
 If yes, describe: _____

5. Has your child previously had his/her hearing tested by an Audiologist? Yes No
 If yes, where? _____
 When? _____
 What were the results? _____

OTHER HISTORY:

1. Does your child have any learning problems? Yes No
 If yes, explain: _____
 Has your child been evaluated for learning difficulties? Yes No
2. Does your child have any speech or language problems? Yes No
 If yes, explain: _____
 Has your child been evaluated by a Speech Language Pathologist? Yes No
 Is your child receiving speech therapy? Yes No
 If yes, how often and with whom? _____
3. Does your child have any known attention deficit or hyperactivity problems? Yes No
 If yes, explain: _____
4. Does your child have any known behavioral problems? Yes No
 If yes, explain: _____

