ETSUHealth
COLLEGE OF CLINICAL AND REHABILITATIVE HEALTH SCIENCES

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Patient Name: _____ DOB: _____ Date: _____

Information provided by: _____ Relationship with child: _____

PEDIATRIC CASE HISTORY QUESTIONNAIRE

Who referred you to this clinic? _____

Do you think your child has difficulty hearing? ☐ YES or ☐ NO

If YES, please describe _____

_____

Developmental/ Birth History:

Birth Hospital: _____ Maternal age at birth: ___ Length of Pregnancy _____ (weeks)
Child's Birth Weight: _____ (lbs., oz.) Birth was: ☐ Induced ☐ Spontaneous ☐ Cesarean
Did your child pass their newborn hearing screening? ☐ YES or ☐ NO

Did any of the following complications occur during pregnancy? Check all that apply:

☐ CMV ☐ Syphilis ☐ Rubella ☐ Herpes
☐ Toxoplasmosis ☐ Other Infection ☐ Alcohol Use ☐ Tobacco use
☐ Recreational drug use

Did any of the following complications occur during/after delivery? Check all that apply:

☐ Assisted Ventilation ☐ Hyperbilirubinemia ☐ Low Birth Weight
☐ ECMO ☐ Blood transfusion ☐ Premature
☐ NICU, how long? _____ ☐ Infection (Medication: _____) ☐ Other: _____

Medical History:

Pediatrician: _____ Clinic, City/State: _____
Does your child receive any services? (such as speech therapy or physical therapy, etc.)
☐ YES or ☐ NO If YES, what services, which provider, and when did services begin/end?

_____

Is your child currently taking any medications? ☐ YES or ☐ NO
If YES, what medications and what dosage? _____
Is your child current on their immunizations? ☐ YES or ☐ NO
Has your child been diagnosed with any of the following? Check all that apply

☐ AIDS/HIV ☐ Diabetes ☐ Head injury
☐ Cancer ☐ Encephalitis ☐ Heart problems
☐ Measles ☐ Chicken Pox ☐ Genetic Disorders
☐ Ear Tags ☐ Ear Pits ☐ Syndromes
☐ Allergies ☐ Seizures ☐ Other

If "Other" please describe: _____
Are there any other medical conditions you feel we should be aware of?

Audiological History:

Does this child have a family history of hearing loss? ☐ YES or ☐ NO
If YES, please describe_____

Has your child received any hearing tests in the past? ☐ YES or ☐ NO
If YES, when/where? _____ _____
Has your child ever been diagnosed with hearing loss? ☐ YES or ☐ NO
If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH was it: ☐ GRADUAL or ☐ SUDDEN
When did you first notice this hearing loss? _____
Do you know the cause of the hearing loss? _____
Does your child wear hearing aids? ☐ YES or ☐ NO If yes, Make/Style: _____
Which ear/s are aided? ☐ RIGHT ☐ LEFT ☐ BOTH
Does your child respond to: ☐ Name ☐ Loud Sounds?
History of noise exposure? ☐ YES or ☐ NO
History of ear infections? ☐ YES or ☐ NO If YES, When and how often? _____ Most recent? _____
Which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH what treatment was provided? _____
PE tubes or any other ear surgeries? ☐ YES or ☐ NO
If YES, when was the surgery and who was the provider?
_____
Has your child had a history of any of the following: (check all that apply)

☐ Ear wax build up	☐ Ear deformity	If YES, please describe:
☐ Ear drainage	☐ Ringing in the ears	_____
☐ Dizziness	☐ Other:	_____

Educational History:

Child's School: _____ Grade: _____

Does this child receive any services through school? ☐ YES or ☐ NO
(such as speech therapy, IEP, etc.) If YES, what services and when did they begin/end?
_____

Is your child enrolled in a special classroom setting? ☐ YES or ☐ NO
If YES, please describe:

Please list any additional information you feel would be important for the provider to be aware of:
_____
_____
_____