Scottsdale Healthcare Medical Center Pediatric Outpatient Pediatric Audiology Case History Form

Identifying Information

Child's Name:	Birth Date:	Sex:	Age:
Person Completing Form: Relation to Patient:	Date:	Daytime Phone:	
Address:	Evening Phone:		
City:	State:	Zip Code:	

Home and Family Information

1st Parent/Guardian's Name:	Occupation:	Age:
2nd Parent/Guardian's Name:	Occupation:	Age:
Child lives with:	Languages spoken in home:	

Other Children in the Family

Name	Age	Sex	Grade Level	List any speech, hearing, learning or medical problems

Referral Information

Who suggested bringing your child to us for care?	☐ Doctor ☐ Counselor/Therapist ☐ School ☐ Self ☐ Friend Name:______________________________
What are your main concerns or reasons for this evaluation?	
At what age was your child's problem first noted? By whom?	

Hearing and Ear History	Describe
Do you think your child has a hearing loss? ☐ Yes ☐ No	
Does your child complain of noise in the ears or head? ☐ Yes ☐ No	
Does your child have dizziness or imbalance? ☐ Yes ☐ No	
Did your child have hearing screening as a newborn? ☐ Yes ☐ No ☐ Outcome: ☐ Passed ☐ Referred	
Name of hospital where child was born:	
Age of first ear infection, diagnosed by a doctor?	
Number of ear infections: age 0 to 2 years? Age 2 to 4 years? Age 4 to 6 years?	
Last ear infection: Date: Age:	
Does your child currently have ventilation tubes? ☐ Yes ☐ No	
Ear surgeries: ☐ Yes ☐ No	Dates:
Has or does your child wear hearing aids? ☐ Yes ☐ No	Date fit:
Hours per day child uses hearing aids	Benefit: ☐ good ☐ fair ☐ marginal

Child's Medical History

<table>
<tr><td colspan="3">List any serious illnesses, injuries, hospitalizations, or other surgeries:</td></tr>
<tr><td>Indicate any of the following that are applicable to pregnancy and birth history:

☐ Prenatal problems
☐ Premature birth
☐ Blood incompatibility
☐ Birth weight of less than 3.3 lbs
☐ Bacterial meningitis
☐ In utero infection, such as rubella, cytomegalovirus, Syphilis, herpes, toxoplasmosis
☐ Ototoxic medications including but not limited to amino glycosides
☐ Apgar scores of 0 to 4 at 1 minutes or 0 to 6 at 5 Minutes after birth
☐ Elevated bilirubin
☐ Other ____________________</td><td colspan="2">Please describe:</td></tr>
<tr><td>List any diagnosis your child has received. For example (You may check those which apply):

☐ Hearing loss
☐ Attention deficit disorder (ADD or ADHD)
☐ Speech/Language disorder
☐ Developmental or delayed
☐ Mentally retarded
☐ Pervasive developmental disorder (PDD) or autism
☐ Cerebral palsy or a motor coordination disorder
☐ Emotional or psychiatric disorder
☐ Other ____________________</td><td colspan="2">Who diagnosed the child and when?</td></tr>
<tr><td colspan="2">Current medications, dosage and reason:</td><td>Has the child taken these medications today? ☐ Yes ☐ No</td></tr>
<tr><td>Have any other specialists seen your child?

☐ Speech-language pathologist
☐ Psychologist
☐ Developmental pediatrics specialist
☐ Special education specialist
☐ Physical therapist
☐ Occupational therapist
☐ Behavior psychologist
☐ Other ____________________</td><td colspan="2">If yes, please describe?</td></tr>
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