Presbyterian ear Institute

PRESBYTERIAN EAR INSTITUTE

415 CEDAR ST SE
ALBUQUERQUE, NM 87106

AUDIOLOGY
Child Case History

Name: _____ DOB: _____ Date: _____

1. For what reason was this appointment arranged?
   _____
   _____

2. Who referred you to Presbyterian Ear Institute? _____

3. Has your child ever had a hearing test? ☐ Yes ☐ No
   Where? _____
   What were the results? _____

4. Did your child receive a hearing screen at birth? ☐ Yes ☐ No
   What Hospital? _____
   Did he/she pass in both ears? ☐ Yes ☐ No

5. Do you have any concerns about your child's hearing? ☐ Yes ☐ No

6. Does your child respond to sounds? ☐ Yes ☐ No

7. Does your child follow verbal directions? ☐ Yes ☐ No

8. Does anyone in the family (***sisters, brothers, aunts, grandparents, etc.***)
   have a hearing loss? If so who? _____ ☐ Yes ☐ No

   Does any one in the family have a language/speech delay? ☐ Yes ☐ No
   If so who? _____

9. Were there any complications during pregnancy or delivery? ☐ Yes ☐ No
   Please explain: _____
   _____

10. Was any of the following present after your child's birth or during the first two months?

- ☐ Stayed in hospital after mother
- ☐ Birth weight less than 5 lbs.
- ☐ Did not respond to sounds or people
- ☐ Was in an incubator or isolette
- ☐ Difficulty breathing
- ☐ High fever
- ☐ Prematurity
- ☐ Poor weight gain
- ☐ Appeared yellow
- ☐ Infections at birth
- ☐ Physical deformities
- ☐ Other _____
  Please describe _____
  _____

Adopted in part from ASHA

11. What is your child's general health? ☐ Good ☐ Average ☐ Poor

12 Is your child taking any medication now? ☐ Yes ☐ No
Please list all medications_____

13. Has your child ever been hospitalized? ☐ Yes ☐ No
Please explain: _____

14. Has your child had any ear infections or other ear disorders? ☐ Yes ☐ No
How many episodes? _____
When was their last ear infection? _____

15. Has your child ever received tubes due to frequent ear infections? ☐ Yes ☐ No

16. Has your child had any ear surgery ☐ Yes ☐ No

17. What illnesses has your child had?

☐	High Fever	☐	Dizziness
☐	Convulsions	☐	Pneumonia
☐	Measles	☐	Heart problems
☐	Head or ear injury	☐	Rheumatic fever
☐	Encephalitis	☐	Allergies
☐	Meningitis	☐	Asthma
☐	Tonsillitis	☐	Other: _____

18. Has you child ever received speech therapy? ☐ Yes ☐ No
If so where and how often? _____

19. Do you have any concerns about your child's speech and language? ☐ Yes ☐ No
If yes, please explain_____

20. Do you have any concerns about your child's physical or mental development? ☐ Yes ☐ No

21. Do you believe your child has any learning problems? ☐ Yes ☐ No

22. Has your child ever received any special services? (***Physical therapy occupational therapy etc....***) ☐ Yes ☐ No
If so where and how often? _____
_____

23. If your child is under 3yrs of age, approximately how many words can your child say? _____

24. What questions would you like to have answered as a result of today's hearing test?_____
_____
_____

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Audiology Case History