Bay Area Audiology
State-of-the Art Hearing Diagnosis & Solutions

PEDIATRIC CASE HISTORY

Name:_____ Date:_____

1. What is the **primary** purpose of today's visit?
   - □ Hearing Concerns □Speech/language concerns
   - □ Newborn hearing screening □Other:_____

2. Do you suspect that your child has **hearing difficulties**?
   - □ Yes If so, please describe concerns:_____
   - □ No

3. Is there any **family history** of hearing problems?
   - □ Yes If so, how are they related:_____
   - □ No

4. Has your child recently experienced any of the following?
   - □ Sudden change in hearing □ Ear pain
   - □ Ear infection □ Ear pressure/fullness
   - □ Ear drainage □ Other:_____

5. Has your child been treated for any **medical issues involving his/her ear(s)**?
   - □ Yes If so, please describe concerns:_____
   - □ No

6. Does your child have any **significant health problems**?
   - □ Yes If so, please describe concerns:_____
   - □ No

7. Does your child have any **speech and/or language problems**?
   - □ Yes If so, please describe concerns:_____
   - □ No

8. Did your child pass his/her **newborn hearing screening**?
   - □ Yes
   - □ No

9. At which hospital was your child born?_____

10. The name of the mother/guardian of the child at the time of birth?_____

11. Did your child spend any time in the **NICU**?
    - □ Yes If so, how many days:_____
    - □ No

12. Were there any **complications at birth**?
    - □ Yes If so, please describe concerns:_____
    - □ No

Additional Comments:_____

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