MONTCLAIR STATE UNIVERSITY

Infant Case History Form – Audiology
(Birth – 3 years)

REASON FOR VISIT & CONTACT INFORMATION

Childs's name: _____ Date of Birth: _____ Age: _____

Gender: ☐ Female ☐ Male Person completing this form: _____

Parent/Guardian (A) Name: _____ Date of Birth: _____

Relationship to child: ☐ Biological ☐ Foster ☐ Grandparent ☐ Step ☐ Adoptive ☐ Other

Address: _____

Telephone: _____ ☐ Cell ☐ Landline Email: _____

Parent/Guardian (B) Name: _____ Date of Birth: _____

Relationship to child: ☐ Biological ☐ Foster ☐ Grandparent ☐ Step ☐ Adoptive ☐ Other

Address: _____

Telephone: _____ ☐ Cell ☐ Landline Email: _____

Primary Language spoken at home _____

Other languages spoken at home or around your child _____

Who cares for your child when you are not with your child? _____

Pediatrician _____ Address/Phone Number _____

If parents are living apart, child mainly lives with: _____

Who has custody of your child? _____

List everyone who lives in the home. _____

What brings you to the clinic today?

PREGNANCY AND DELIVERY HISTORY

Length of Pregnancy: _____ Birth weight: _____

Hospital of delivery: _____

Type of delivery: _____ Was labor induced: ☐ Yes ☐ No

Did your child spend any time in the NICU? ☐ Yes ☐ No

If yes, for how long? _____

Did your child receive oxygen (nasal cannula) after delivery? ☐ Yes ☐ No

If yes, for how long? _____

Was your child placed on mechanical ventilation after delivery? ☐ Yes ☐ No

If yes, for how long? _____

Was your child transferred to another hospital? ☐ Yes ☐ No

If yes, where? _____

Were there any complications during pregnancy and delivery. ☐ Yes ☐ No

If yes, describe:

_____

What was your child's last APGAR score? ☐ Don't know ☐ Score was less than 7 ☐ Score was 7 or more

Did any of the following occur during pregnancy? (check all that apply)

☐ Alcohol abuse	☐ Herpes	☐ Rh Incompatibility	☐ Toxemia
☐ Communicable disease	☐ Maternal Infection	☐ Smoking	☐ Toxoplasmosis
☐ Cytomegalovirus (CMV)	☐ Maternal illness	☐ Substance abuse	☐ Venereal disease
☐ German measles/Rubella	☐ Maternal X-rays	☐ Syphilis	☐ Zika Virus

Other (describe)) _____

List any medications that were taken during pregnancy and delivery.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Has your child taken or is currently taking any of the following medications? (check all that apply)

☐ Vancomycin ☐ Gentamycin Other, please list

☐ Chemotherapy ☐ Streptomycin _____

HEALTH HISTORY

Has your child had a fever greater than 104°? ☐ Yes ☐ No

If yes, how old was your child? _____ How long did it last? _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, what procedures or treatments were performed?

_____

Has your child had any of the following? (check all that apply)

- ☐ Ear infection/fluid
- ☐ CMV
- ☐ Toxoplasmosis
- ☐ Herpes simplex
- ☐ Seizures
- ☐ Blood transfusion
- ☐ Meconium stain or aspiration
- ☐ Rubella
- ☐ Breathing difficulties

HEARING HISTORY

What was your child's name at birth? _____

What were the results of your child's newborn hearing screening?

☐ Passed both ears ☐ Did not pass both ears ☐ Did not pass-left ear only ☐ Did not pass-right ear only

If your child did not pass the hearing screening, what follow-up steps did you take? _____

Where did you have the follow-up done? _____

What were the results? _____

Does your child have any brothers or sisters who have hearing loss? ☐ Yes ☐ No

If so, please explain _____

Factors associated with hearing loss (check all that apply)

- ☐ Family history of hearing loss
- ☐ Jaundice (requiring transfusion)
- ☐ Bacterial meningitis
- ☐ Pulmonary hypertension
- ☐ Other
- ☐ Head trauma (hospitalization required
- ☐ CHARGE syndrome
- ☐ Down syndrome (Trisomy 21)
- ☐ Cleft lip and palate Small/absent ear(s)
- ☐ Skin tags or pits around the ear(s)
- ☐ Rh incompatibility

If other describe: _____

Does your child startle to loud sounds? ☐ Yes ☐ No

If yes, what does your child do? _____

Does your child quiet to your voice or music? ☐ Yes ☐ No

Do you think your child hears? ☐ Yes ☐ No

Describe how you know your child hears.

_____

Has your child had any other hearing tests? ☐ Yes ☐ No

If yes, what were the results? _____

How many ear infections has your child had? _____

DEVELOPMENTAL MILESTONES

At what age did your child:

Say their first word?	_____	Years	_____	Months
Speak in three word sentences?	_____	Years	_____	Months
Hold their head erect?	_____	Years	_____	Months
Sit unsupported?	_____	Years	_____	Months
Walk alone?	_____	Years	_____	Months

How does your child communicate with others? _____

How much of your child's speech can be understood…

By the family? ☐ Yes ☐ No ☐ Sometimes

Explain: _____

By others? ☐ Yes ☐ No ☐ Sometimes

Explain: _____

Do you have any concerns about your child's speech? ☐ Yes ☐ No

If yes, explain _____

SOCIAL/OTHER SERVICES

Is your child registered with the State Child Health Services? ☐ Yes ☐ No

If yes, does your child have a case manager? ☐ ☐

If yes, what is the case manager's name? _____

What is the case manager's contact information? _____

Does your child receive Early Intervention (EI) services? ☐ Yes ☐ No

If yes, what is the case manager's name? _____

What is the case manager's contact information? _____

Has your child received speech/language therapy? ☐ Yes ☐ No Where? _____

Describe the therapy (how often, how long) _____

Has your child received physical therapy? ☐ Yes ☐ No Where? _____

Describe the therapy (how often, how long)

Has your child received occupational therapy? ☐ Yes ☐ No Where? _____

Describe the therapy (how often, how long)

Has your child received any other services? ☐ Yes ☐ No Where? _____

Describe the therapy (how often, how long)

Does your child attend day care/preschool? ☐ Yes ☐ No Where? _____

AMPLIFICATION/ IMPLANT HISTORY

Does your child use hearing aids now? ☐Yes ☐No

If yes, please answer the following questions.

How long has your child used hearing aids? _____

In which ear(s) does your child wear hearing aids ☐ Left ☐ Right ☐ Both

What is the make & model of the left hearing aid? _____

How long has your child had this hearing aid? _____

What is the make & model of the right hearing aid? _____

How long has your child had this hearing aid? _____

If your child used hearing aids in the past is s/he still wearing aids? ☐ Yes ☐ No

If no, why not? _____

Does your child use a cochlear implant(s) now? ☐ Yes ☐ No

If yes, please answer the following questions.

How long has your child used cochlear implants? _____

In which ear(s) does your child use a cochlear implant ☐ Left ☐ Right ☐ Both

What is the make & model of the left cochlear implant? _____

How long has your child had this cochlear implant? _____

What is the make & model of the right cochlear implant? _____

How long has your child had this cochlear implant? _____

Does your child use an FM system or other listening device now? ☐Yes ☐No

If yes, please describe. _____

FINSIH UP

Is there any other information that we should know so that we can help you and your child?

_____

_____

_____

Who can we thank for referring you to CASLP? _____

Name of the person completing this form: _____

Relation to the client? _____

Signature _____ Date: _____