MONTCLAIR STATE UNIVERSITY

Pediatric Case History Form – Audiology
(3 – 18 years)

CONTACT INFORMATION

Child's name: _____ Date of Birth: _____ 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 _____

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 is the reason for your child's visit to the clinic?

PRENATAL AND DELIVERY HISTORY

Length of Pregnancy: _____ Birth weight: _____

Complications during pregnancy ☐ Yes ☐ No

If yes, describe? _____

Hospital of delivery: _____

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

If yes, for how long? _____

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	☐ Communicable diseases	☐ Cytomegalovirus (CMV)
☐ German Measles/rubella	☐ Maternal illness	☐ Maternal X-rays
☐ Infections	☐ Rh Incompatibility	☐ Smoking
☐ Substance abuse	☐ Toxemia	☐ Toxoplasmosis
☐ Venereal disease	☐ Zika virus	

Other (describe) _____

HEALTH HISTORY

Has your child ever taken any of the following medications? (check all that apply)

☐ Vancomycin	☐ Gentamycin	Other, please list
☐ Chemotherapy	☐ Streptomycin	_____

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 ever been seen by a specialist? ☐ Yes ☐ No

If yes, who _____ When? _____

Reason? _____

Outcome? _____

HEALTH HISTORY

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

- ☐ Allergies
- ☐ Blood transfusion
- ☐ Breathing difficulties
- ☐ Chicken Pox
- ☐ Cytomegalovirus (CMV)
- ☐ Draining ear(s)
- ☐ Ear infections/fluid
- ☐ Encephalitis
- ☐ Flu
- ☐ Frequent colds
- ☐ Head injury
- ☐ High fevers
- ☐ Measles
- ☐ Meconium stain or aspiration
- ☐ Meningitis
- ☐ Mumps
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Tonsillitis

Has your child had medical or surgical treatment of their ears (for example, PE tubes)? ☐ Yes ☐ No

Does your child ever complain of pain or fullness in their ears? ☐ Yes ☐ No

Has your child ever been exposed to loud noises or an explosion? ☐ Yes ☐ No

Has your child ever described noises in their ears? ☐ Yes ☐ No ☐ Left ear ☐ Right ear ☐ Both ears

Does your child fall or lose balance easily? ☐ Yes ☐ No

Has your child been diagnosed with any specific condition? ☐ Yes ☐ No

If so, what is your child's condition? _____

List any medications that your child is taking

_____

HEARING HSTORY

Factors associated with hearing loss (check all that apply)

- ☐ Family history of hearing loss
- ☐ Jaundice (requiring transfusion)
- ☐ Bacterial meningitis
- ☐ Pulmonary hypertension
- ☐ Head trauma (hospitalization required)
- ☐ Other
- ☐ 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:

Do any of your child's siblings or other family members have hearing loss? ☐ Yes ☐ No

If yes, please list

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

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

Has your child had a hearing test? ☐ Yes ☐ No

If yes, when? What were the results?

HEARING HISTORY

How many ear infections has your child had? _____ When was the last one? _____

Do you think you child has a hearing problem? ☐ Yes ☐ No

If yes, what makes you think so? _____

If no, what makes you think so? _____

Does your child . . .

Respond consistently to sounds? ☐ Yes ☐ No
Turn to find a sound source? ☐ Yes ☐ No
Enjoy listening to music? ☐ Yes ☐ No
Respond to their name ☐ Yes ☐ No
Startle to loud sounds? ☐ Yes ☐ No

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 _____

SCHOOL\OTHER SERVICES

Has your child received speech 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? _____

Does your child attend school? ☐ Yes ☐ No Where? _____

Is your child home-schooled? ☐ Yes ☐ No

LISTENING & ATTENDING BEHAVIOR

Do you think your child has a problem listening or understanding? ☐ Yes ☐ No

Give some examples _____

Does your child have trouble with any subjects in school? ☐ Yes ☐ No

If yes, please list _____

What are your child's best subjects _____

Select all the behaviors/characteristics your child displays

☐ Awkward, clumsy, poor coordination	☐ Overly active	☐ Prefers solitary activities	☐ Destructive
☐ Does opposite of what is requested	☐ Impulsive	☐ Seeks attention	☐ Inappropriate social behavior
☐ Reverses words, numbers, letters	☐ Daydreams	☐ Disruptive or rowdy	☐ Does not complete assignments
☐ Difficulty understanding sarcasm, humor, or figures of speech	☐ Prefers to play with younger children	☐ Temper tantrums	☐ Easily frustrated
☐ Lacks musical ability	☐ Difficulty making friendships	☐ Shy	☐ Tires easily
☐ Restless, problems sitting still	☐ Sensitive to loud sounds	☐ Anxious	☐ Irritable
☐ Short attention span	☐ Easily upset by new situations	☐ Lacks self-confidence	☐ Dislikes school
☐ Easily distracted	☐ Difficulty following directions	☐ Lacks motivation	☐ Fakes illnesses
☐ Forgetful	☐ Appears to be confused in noisy places	☐ Uncooperative	☐ Difficulty expressing him/herself
☐ Prefers to play with older children	☐ Asks for repetition	☐ Disobedient	

AMPLIFICATION 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? _____

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: _____