WACO Hearing Center

254.878.4040
www.WacoHearingCenter.com

Pediatric Audiology Case History

To be completed by a parent or guardian.

Date: _____

Client's Name (Please Print): _____
Full Name Nickname

Birthdate: _____ Age: _____ Gender: ☐ Female ☐ Male

Primary Care Physician's Name: _____ Location: _____

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Referred By: _____

Name of Person Giving Information: _____ Relationship: _____

Family Information

Parent(s) or Guardian(s) Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Email(s): _____

Names and ages of other children in the family:

_____

_____

_____

_____

The following questions are designed to help us evaluate your child's auditory system. Please answer them as accurately and completely as possible. If a question does not apply, please write NA.

1. What is the primary reason for this appointment? _____

   _____

   _____

2. Do you feel your child's hearing is stable, or does it fluctuate? _____

   _____

   _____

3. Has he/she been diagnosed with any medical conditions or developmental disabilities?

   ☐ Yes ☐ No If yes, please list diagnoses: _____

4. Does your child have a history of ear infections? ☐ Yes ☐ No

   If yes, how many ear infections have they had? _____

5. Have tubes been placed in your child's ears, or has your child had other ear surgeries? ☐ Yes ☐ No
   If yes, how many sets of tubes or what type of ear surgery? _____

6. To your knowledge, did your child pass their newborn hearing screening? ☐ Yes ☐ No

7. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age? ☐ Yes ☐ No
   If yes, who in the family has a hearing loss and at what age? _____

8. Has your child's hearing been tested before by an audiologist? ☐ Yes ☐ No
   If yes, when was the last hearing test? _____ Where? _____ Results: _____

9. Does your child currently wear hearing aids? ☐ Yes ☐ No
   If yes, how old are the current aid(s)? _____

Medical History *Was any of the following present in your child's life? Please check all that apply.*

- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Allergies
- ☐ Neonatal intensive care for more than five days
- ☐ Hyperbilirubinemia (jaundice)
- ☐ Anoxia (oxygen deprivation)
- ☐ Ototoxic medications (e.g., gentamycin, aminoglycoside, loop diuretics)
- ☐ Infections at birth or in utero (e.g., CMV, herpes, rubella, syphilis, toxoplasmosis)
- ☐ Postnatal infections associated with hearing loss (e.g., herpes, meningitis)
- ☐ Syndromes associated with hearing loss (e.g., neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome)

Academic Development

1. Is your child in school? ☐ Yes ☐ No Grade: _____
2. How would you describe your child's academic performance/progress? _____
3. In what area is your child having difficulty? _____
4. Where is your child seated in the classroom? _____
5. Does your child currently receive support services (including speech-language therapy, occupational therapy, physical therapy, special education)? ☐ Yes ☐ No
   If yes, please explain the type of services: _____
6. Does your child seem to have any of the following issues? Please check all that apply.
   - ☐ Problems following directions
   - ☐ Distracted by background noise
   - ☐ Oral and written expression problems
   - ☐ Remembering what they hear
   - ☐ Difficulty with multistep directions
   - ☐ Difficulty learning to read