PEDIATRIC EAR and HEARING CASE HISTORY

Child's Name:_____ Age:_____

What concern(s) are you here for today?

_____ Ear Problems (pain/infections) _____ Hearing Loss _____ Dizziness

_____ Speech and Language _____ Other

If other, please specify here:_____

1. Do you suspect your child has a hearing loss? _____ Yes _____ No

2. Do you believe that one ear hears **better** than the other?

_____ Right _____ Left _____ Neither

3. Does your child:

Respond when called from another room? _____ Yes _____ No

Look to a sound source? _____ Yes _____ No

4. Do you have concerns with how your child talks? _____ Yes _____ No

If you have concerns with your child's speech and language:
Has your child received a speech/language evaluation by a Speech Language Pathologist? _____ Yes _____ No

Does your child currently attend or will they begin attending speech and language therapy? _____ Yes _____ No

5. Does your child:

Say at least 10 words? _____ Yes _____ No

Say 2 – 3 word sentences? _____ Yes _____ No

Speak clearly to the family? _____ Yes _____ No

6. How many ear problems has your child experienced? (please circle)

0-2 2-4 4-6 6-8 10 or more

7. Check all the ear problems your child has experienced:

_____ Ear wax build-up _____ Outer/ear canal infection (swimmer's ear)

_____ Middle ear infection/fluid _____ Inner ear infection (dizziness/vomiting)

_____ Ear pain

TURN OVER FOR MORE QUESTIONS

8. Has your child received Pressure Equalization Tubes ("ear tubes")?

_____ Yes _____ No

If **yes**, how many sets of tubes have they received and when:_____

_____

9. Does your child currently have tubes in their eardrums?_____ Yes _____ No

10. Does anyone in household/daycare smoke cigarettes?_____ Yes _____ No

11. Please list/describe any general health concerns; pregnancy/birth history, disease/disorder, etc…your child has experienced in the past or currently experiences:_____

_____

_____

_____

_____

12. Does your child regularly experience:

Allergies? _____ Yes _____ No

Runny nose? _____ Yes _____ No

Congested nose? _____ Yes _____ No

How are their sinuses today?

_____ Clear _____ Mostly Clear _____ Mostly Congested _____ Congested

13. Do you have any concerns with your child's behavior? _____ Yes _____ No

If **yes**, please explain:_____

_____

14. Who referred you and your child to this office?_____

By signing below you verify the above information is accurate and you authorize Advanced Audiology, LLC to perform testing, care and management services relating to your child's hearing health care needs.

_____ _____

Parent/Guardian Signature: Relationship to patient:

_____ _____

Witness Signature: Date: