



**PEDIATRIC CASE HISTORY**

Information provided by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE of BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: Male / Female

SCHOOL ATTENDING: \_\_\_\_\_ GRADE: \_\_\_\_\_

PATIENT'S PEDIATRICIAN: \_\_\_\_\_  
*NAME TELEPHONE #*

PRIMARY CONCERN: \_\_\_\_\_

HOW CAN WE HELP? \_\_\_\_\_

**GENERAL INFORMATION**

PARENT'S NAME: \_\_\_\_\_  
*LAST FIRST (MAIDEN)*

PARENT'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

PARENT'S SS# \_\_\_\_\_ PARENT'S D.O.B. \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_  
*LAST FIRST (MAIDEN)*

PARENT'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

PARENT'S SS# \_\_\_\_\_ PARENT'S D.O.B. \_\_\_\_\_

LEGAL GUARDIAN'S NAME: \_\_\_\_\_

GUARDIAN'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

**PREGNANCY HISTORY**

COMPLICATIONS DURING PREGNANCY: \_\_\_\_\_

EXPLAIN: \_\_\_\_\_

MEDICATIONS/ DRUGS USED DURING PREGNANCY? \_\_\_\_\_

HOW OFTEN: \_\_\_\_\_

ALCOHOL USE DURING PREGNANCY? \_\_\_\_\_ HOW OFTEN: \_\_\_\_\_

**BIRTH HISTORY**

CHILD'S PLACE OF BIRTH: \_\_\_\_\_

CHILD'S BIRTH WEIGHT: \_\_\_\_\_ PLURALITY: \_\_\_\_\_ PREMATURITY: \_\_\_\_\_

HOW MANY WEEKS EARLY OR LATE? \_\_\_\_\_

DID YOUR CHILD REQUIRE INTENSIVE CARE NURSERY AFTER BIRTH? \_\_\_\_\_

REASON: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

NEWBORN HEARING SCREENING PERFORMED AT BIRTH? \_\_\_\_\_ RESULTS: \_\_\_\_\_

CURRENT DIAGNOSIS OF CHILD: \_\_\_\_\_

**AUDIOLOGICAL HISTORY**

IS THERE A HISTORY OF HEARING LOSS IN THE FAMILY? (*Explain*) \_\_\_\_\_

\_\_\_\_\_

DO YOU THINK YOUR CHILD HAS A HEARING PROBLEM? (*explain*) \_\_\_\_\_

\_\_\_\_\_

HAS YOUR CHILD EVER HAD A HEARING TEST? \_\_\_\_\_ WHEN: \_\_\_\_\_

WHERE? \_\_\_\_\_ RESULTS: \_\_\_\_\_

IS THERE A HISTORY OF MIDDLE EAR INFECTION/ FLUID? \_\_\_\_\_

HOW OFTEN? \_\_\_\_\_

WHO HAS TREATED YOUR CHILD'S EAR INFECTIONS? \_\_\_\_\_

HOW HAVE THE INFECTIONS BEEN TREATED? \_\_\_\_\_

DOES YOUR CHILD RESPOND TO HIS/HER NAME? \_\_\_\_\_

DOES YOUR CHILD RESPOND TO VERBAL DIRECTIONS CONSISTENTLY? \_\_\_\_\_

NOTES: \_\_\_\_\_

\_\_\_\_\_

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**DEVELOPMENT**

DO YOU FEEL THAT YOUR CHILD'S SPEECH AND LANGUAGE SKILLS ARE NORMAL FOR HIS/HER AGE? IF NOT, DESCRIBE YOUR CHILD'S SPEECH AND LANGUAGE:

TO YOUR KNOWLEDGE HAS YOUR CHILD'S OTHER DEVELOPMENTAL MILESTONES BEEN WITHIN THE NORMAL RANGE? IF NOT EXPLAIN: \_\_\_\_\_

WHEN WAS THE DELAY/DIFFCULTY NOTICED? \_\_\_\_\_

TO YOUR KNOWLEDGE IS YOUR CHILD'S BEHAVIOR WITHIN THE NORMAL RANGE FOR HIS/HER AGE? IF NOT, EXPLAIN: \_\_\_\_\_

WHEN WAS THIS NOTICED? \_\_\_\_\_

DOES YOUR CHILD HAVE ANY ALLERGIES AND IF SO TO WHAT? \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING? \_\_\_\_\_

**EDUCATION**

IF YOUR CHILD IS IN SCHOOL, IS HE/SHE HAVING ANY ACADEMIC DIFFICULTIES? EXPLAIN: \_\_\_\_\_

HAS YOUR CHILD EVER REPEATED A GRADE? \_\_\_\_\_ WHAT GRADE? \_\_\_\_\_

DOES YOUR CHILD RECEIVE ANY THERAPY? \_\_\_\_\_

PLEASE USE THIS SECTION TO PROVIDE US WITH ANY ADDITIONAL INFORMATION THAT MAY BE HELPFUL

**IF YOUR CHILD HAS PREVIOUSLY BEEN DIAGNOSED WITH A HEARING LOSS, PLEASE FILL OUT THIS INFORMATION:**

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WHO HAS PREVIOUSLY DIAGNOSED YOUR CHILD WITH A HEARING LOSS? \_\_\_\_\_

WHEN? \_\_\_\_\_

HAVE YOU MET WITH AN OTOLARYNGOLOGIST (EAR, NOSE, & THROAT)? \_\_\_\_\_

NAME OF ENT: \_\_\_\_\_

WHAT HAVE YOU BEEN TOLD ABOUT YOUR CHILD'S HEARING LOSS? \_\_\_\_\_

HOW CAN WE HELP YOU? \_\_\_\_\_

DOES YOUR CHILD WEAR HEARING AIDS? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

WHAT TYPE: \_\_\_\_\_ DOES YOUR CHILD WEAR IT FULL TIME? \_\_\_\_\_

IF NOT, WHY? \_\_\_\_\_ DOES YOUR CHILD LIKE TO WEAR THE HEARING AIDS \_\_\_\_\_

DOES YOUR CHILD USE AN FM SYSTEM IN CLASS? \_\_\_\_\_ WHAT TYPE? \_\_\_\_\_

PLEASE USE THIS SPACE TO PROVIDE US WITH ANY OTHER ADDITIONAL INFORMATION THAT MAYBE HELPFUL

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**Please complete the following checklist for your child, if he/she is school aged.**

<b>AUDITORY BEHAVIORS</b>	<b>FREQUENTLY</b>	<b>OCCASIONALLY</b>	<b>NEVER OBSERVED</b>
Inconsistent responses to sound			
Difficulty following long or complicated instructions			
Short attention span			
Fatigue with long or complex activity			
Distracted by visual and auditory stimuli			
Inability or confusion carrying out verbal instructions			
Fear of loud noises			
Delayed responses to auditory information			
Reading problems			
Spelling difficulties, poor handwriting			
Strength in math, art , music			
Lack of coordination			
Behavior problems in class			
Poor self-concept			
"Don't care" attitude toward learning			
Word finding problems			
Difficulty relating sequences of events			
Daydreaming or episodes of being "out in space"			
Irritable when talking on the phone in noisy environment			

Name of Person Completing this form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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