

# Ears of Ardmore, Inc.

1505 N Commerce Ste 111

Ardmore, Ok 73401

## Case History- Pediatric

To be completed by a parent or guardian

Throughout this form, if the question does not apply, please write N/A.

(Please Print)

Date \_\_\_\_\_

Client's Name \_\_\_\_\_  
Last First MI

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender:  Female  Male

Height \_\_\_\_\_ Weight \_\_\_\_\_

Child lives with: \_\_\_ both parents \_\_\_ Mother \_\_\_ Father \_\_\_ Other

Names and ages of any other children at home: \_\_\_\_\_  
\_\_\_\_\_

Name and address of Child's School, Preschool or Child Care Setting \_\_\_\_\_  
\_\_\_\_\_

### Hearing History

Yes

No

1. Do you have any concerns about your child's hearing?  
If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_
2. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30? \_\_\_\_\_
3. Does anyone in your family have night blindness? \_\_\_\_\_
4. Does your child consistently respond to your voice? \_\_\_\_\_
5. Does your child respond to loud noises? \_\_\_\_\_
6. When sound is present or someone is speaking, does your child search to find where the sound is coming from? \_\_\_\_\_
7. Does your child respond to sounds from other rooms? \_\_\_\_\_
8. Does your child enjoy listening to music? \_\_\_\_\_
9. Has your child's hearing ever been tested?  
If yes, please list by whom, when and results: \_\_\_\_\_  
\_\_\_\_\_
10. Does your child wear hearing aid(s)?  
If yes, please list by whom, when and results: \_\_\_\_\_  
\_\_\_\_\_
11. Does your child use an auditory trainer? \_\_\_\_\_
12. Does your child receive preferential classroom seating? \_\_\_\_\_

**Pregnancy And Birth History**

**Yes**

**No**

- 1. Was the pregnancy abnormal in any way? \_\_\_\_\_
  - 2. Was the delivery abnormal in any way? \_\_\_\_\_
  - 3. Was the delivery premature? \_\_\_\_\_
  - 4. Did the mother have any illness during the pregnancy? \_\_\_\_\_
  - 5. Did the mother take any medication during the pregnancy? \_\_\_\_\_
  - 6. After birth, did your child have:
    - Breathing difficulties? \_\_\_\_\_
    - Require an incubator? \_\_\_\_\_
    - Any head, neck or ear abnormalities? \_\_\_\_\_
    - Feeding problems? \_\_\_\_\_
    - Surgery? \_\_\_\_\_
    - Any infections requiring medication? \_\_\_\_\_
    - Treatment for jaundice (yellow coloration of the skin)? \_\_\_\_\_
- If yes to any of the above, briefly explain: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Medical History**

- 1. Do you have any medical concerns about your child? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, briefly explain: \_\_\_\_\_
- 2. Please check if your child has had any of the following:

Ear infections	_____	Meningitis	_____	Seizures	_____
Ear surgery	_____	Measles	_____	Kidney problems	_____
Hospitalization	_____	Mumps	_____	Vision problems	_____
Head trauma	_____	Allergies	_____	Chicken Pox	_____
Noise exposure (farm equipment, loud noise)	_____	Asthma	_____		_____

Briefly explain any you checked: \_\_\_\_\_
- Other significant medical concerns: \_\_\_\_\_
- 3. Please list any prescriptions or over-the-counter medications your child is taking and for what reason(s): \_\_\_\_\_

**Physical Development History**

- 1. Do you have any concerns about your child's physical development? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, briefly explain: \_\_\_\_\_
- 2. About what age did your child: hold his/her head erect \_\_\_\_\_  
sit unsupported \_\_\_\_\_ walk alone \_\_\_\_\_
- 3. At what age was toilet training completed? \_\_\_\_\_
- 4. Does he/she lose their balance or fall easily? \_\_\_\_\_ yes \_\_\_\_\_ no
- 5. Does he/she seem uncoordinated or clumsy? \_\_\_\_\_ yes \_\_\_\_\_ no

**Speech and Language History**

1. Do you have any concerns about your child's speech and language?  yes  no  
If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_
2. About what age did your child: follow simple directions \_\_\_\_\_  
say his/her first word \_\_\_\_\_ put two words together \_\_\_\_\_
3. Did your child continue adding words after the first word?  yes  no
4. If your child is 2 years old or younger, how many words does he/she use? \_\_\_\_\_
5. Does your child often use gestures when communicating?  yes  no
6. Is your child's speech understood by:  
parents  yes  no siblings  yes  no other adults  yes  no
7. Has your child's speech ever been evaluated?  yes  no  
If yes, please list by whom, when and results: \_\_\_\_\_
8. Is your child currently receiving speech therapy?  yes  no

**Additional History**

1. Do you have any other concerns about your child?  yes  no  
If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_
2. Does your child:  
play/interact well with other children?  yes  no  
have attention/concentration difficulties?  yes  no  
receive any special educational services?  yes  no  
  
If yes to any of the above, briefly explain: \_\_\_\_\_  
\_\_\_\_\_
3. Do you feel that your child is having any difficulty in school?  yes  no  
If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient