Better Sound Audiology Pediatric Case History Form

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Child's Name: _____ **Appointment Date: _____**

Address _____ **Phone _____**
Street City State Zip

Date of Birth: _____ **Age _____** **Gender:** Male or Female

Primary Language Spoken in the Home: _____ **Other languages spoken: _____**

Email Address _____

Other Children in the family and their ages: _____

Was the child adopted? Yes No

If yes, from what country: _____

Age of child when adopted: _____

Family Physician _____ **Date last seen _____**

Reason for visit _____

Reason for today's visit (your concern):_____

Father's information

Full Name _____**DOB:**_____

Place of Employment _____

Business Address_____

Business Phone _____

Position _____

Social Security Number _____

Military Branch_____Years Served_____

Mother's Information

Full Name _____**DOB:**_____

Place of Employment _____

Business Address_____

Business Phone _____

Position_____

Social Security Number _____

Military Branch_____Years Served_____

Who has legal custody of this child _____
(Name) (Relationship)

_____
(Address) (Phone)

Insurance Information - ***Please give you insurance cards to our front office staff so we can make a copy for our records.***

Type of Insurance _____ Member ID # _____

Insured's name _____ Relationship to Patient _____

Birth History

Age of mother during pregnancy: _____ years **Length of pregnancy: _____ weeks**

Did the mother experience any complications during pregnancy, labor or delivery, including illnesses, conditions, accidents, etc.: Yes No

If yes, please describe: _____

Was labor: Spontaneous Induced Cesarean

Length of labor: _____ hours

Did the mother use tobacco or smoke during pregnancy? Yes No

If yes, number of cigarettes/uses per day: _____

Did the mother drink alcoholic beverages (more than one drink per week) during pregnancy?: Yes No

If yes, what was the frequency and amount consumed: _____

Did the mother use recreational drugs during pregnancy?: Yes No

If yes, what drugs and how often: _____

Did the mother take any other medications during pregnancy (other than vitamins)?: Yes No

If yes, what drugs and for what condition(s): _____

Child's birth weight: _____

At birth, did the baby suffer from or experience any of the following complications (please check all that apply):

- ◊ Jaundice
- ◊ Breech birth
- ◊ Low birth weight
- ◊ Blue color
- ◊ Breathing/respiratory difficulties
- ◊ Premature birth
- ◊ Low APGAR score
- ◊ Infection of baby or mother
- ◊ Cesarean birth
- ◊ Sucking/swallowing difficulties
- ◊ Induced labor

Did your child pass their Newborn Hearing Screening? Yes No

Any other conditions or complications at birth: _____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence: _____

_____

Allergies (food, medications, plastics, etc.): _____

_____

Has the child experienced any of the following major medical conditions (please check all that apply):

_____ AIDS/HIV	_____ Diphtheria	_____ High Blood Pressure	_____ Mumps
_____ Appetite Change	_____ Encephalitis	_____ High Fevers	_____ Scarlet Fever
_____ Asthma	_____ Fatigue	_____ Influenza	_____ Stroke
_____ Blood Disorders	_____ Genetic Disorders	_____ Malaise	_____ Tonsillitis
_____ Cancer	_____ Headaches	_____ Malaria	_____ Typhoid
_____ Chicken Pox	_____ Head Injury	_____ Measles	_____ Vascular Problems
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _____

Please check all medical symptoms that apply:

_____Eye Problems (such as blurred vision, pain):

_____Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain)

_____Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations)

_____Respiratory Symptoms (such as shortness of breath, cough, wheezing)

_____Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain)

_____Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)

_____Psychiatric Issues (such as depression, anxiety, compulsions)

_____Endocrine Symptoms (such as frequent urination, hot flashes)

_____Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands)

_____Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)

Additional Comments: _____

_____

Has the child been immunized? Yes No

If yes, for which of the following (please check all that apply) :

◊ Anthrax	◊ Influenza	◊ Rabies
◊ Chicken Pox	◊ Measles	◊ Rotavirus
◊ Diphtheria	◊ Meningococcus	◊ Rubella
◊ Hepatitis A	◊ Mumps	◊ Smallpox
◊ Hepatitis B	◊ Pertussis	◊ Tetanus
◊ Hib	◊ Pneumonia	◊ Zoster
◊ Human Papillomavirus	◊ Polio	

Audiologic History

How does the child respond to spoken directions or questions? _____

Does the child respond to loud noise? Yes No

Please describe the noise: _____

Has the child ever had a hearing test? Yes No If so, when? _____

Does the child experience hearing loss? Yes No If so, which ear? Right Left Both

If he/she does experience hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice the child's hearing loss? _____

What do you think is the cause of the child's hearing loss? _____

Does the child have a history of ear infections? Yes No

If Yes: First occurrence: _____ Frequency: _____

Most recent: _____ Treatment(s): _____

Has the child ever had ear tubes surgically inserted? Yes No

If Yes, when: _____

Has the child ever worn or tried a hearing aid? Right Ear Left Ear Both Ears

Please check all medical conditions that apply:

_____ **Dizziness or Unsteadiness** *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____ **Ear Deformity** *If checked, Right ear Left Ear Both ears*

_____ **Ear Drainage** *If checked, Right ear Left Ear Both ears*

_____ **Ear Pain/Earaches** *If checked, Right ear Left Ear Both ears*

_____ **Family History of Hearing Loss** *If checked, who?* _____

_____ **History of Ear Wax Buildup**

_____ **Tinnitus/Ringing/Noises in ears** *If checked, Right ear Left Ear Both ears*

_____ **Other:** *Please describe:* _____

Developmental and Educational History

Does the child's rate of development seem normal to you? Yes No

When did the child first:

Hold his/her head up alone: _____ **Crawl: _____**

Sit alone without support: _____ **Babble: _____**

Walk unattended: _____ **Feed themselves: _____**

Become toilet trained: _____ **Begin to say single words: _____**

Combine words into small sentences: _____ **Use more complete sentences: _____**

Please describe the child's gross motor (running and jumping) and fine motor (coloring and writing) skills:

_____

Has the child ever been diagnosed with, or treated for, any of the following:

Neurological problems Yes No

ADHD/ADD Yes No If yes, what medication(s) are they currently taking? :_____

Articulation/speech disorder Yes No

Learning Disability Yes No

Language Disorder Yes No

Physical Impairment(s) Yes No If yes, please describe: _____

Other (please specify): _____

Has your child undergone any of the below listed therapies?

Speech/Language Therapy Yes No If yes, please describe: _____

Occupational Therapy Yes No If yes, please describe: _____

Physical Therapy Yes No If yes, please describe: _____

Vision Therapy Yes No If yes, please describe: _____

Other (please specify): _____

Please describe the child's social development and interactions: _____

_____

Child's School: _____

Current Grade: _____

Is the child enrolled in a special classroom setting? Yes No

If yes, please describe: _____

Does their classroom have an FM system? If yes, Personal Classroom

Additional Comments:

_____

_____

_____

_____

Medication List **Please list all prescriptions, vitamins, and recreational medications**			
Medication	**Dosage**	**Frequency**	**Administered**

POLICY

We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.

_____
Initials

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made on my behalf to Better Sound Audiology for services furnished to me by the provider. I authorize any holder of medical information about me to release to Better Sound Audiology any information needed to determine these benefits or the benefits payable for related services.

_____
Initials

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize you to release to my attorney(s), and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.

_____
Initials

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Better Sound Audiology & Hearing Aid service a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

_____
Initials

_____ _____ _____

Signature of person completing this form **Relationship to child** **Date**