Pediatric Case History Form

Patient Name_____ Birth date_____ Age_____

Referred by? _____

Reason for today's visit:_____
___Speech or language delay
___Failed hearing screening
___Newborn hearing screening
___Other (please explain)_____

Has your child had a hearing test before? Yes No

Is there a history of childhood hearing loss in the family? Yes No

If Yes, Who? _____

Has your child ever had ear infections? Yes No

If so, how many and date of most recent infection?_____

Has your child ever had ear surgery? Yes No

If so, please explain:_____

Please check all that apply:

___Premature birth ___Oxygen required at birth ___Low birth weight (under 5 lbs)

___Failed newborn hearing test ___Developmental delay ___Pediatric intensive care at birth

___Wears hearing aids ___Chronic illness or genetic disorders (please explain)

_____

Any additional comment of information that you would like us to know: _____

_____

_____

_____

Please list any medications taken on a regular basis **on back of form**. →

Signature of parent or guardian _____ Date _____

Patient Medication Information

Name: _____ DOB: _____ DATE: _____

Please list all medications below.

(Including Over the Counter/Vitamins/Herbal Supplements)

Medication	Dosage/Strength	Frequency	Route of administration (oral, injection, etc.)

Reviewed by: Clinician Date

_____ _____

_____ _____

_____ _____