



**FAIRBANKS
HEARING &
BALANCE**

— CENTER —

1919 Lathrop St #104 • Fairbanks, AK 99701 • Ph: (907)456-7768 • Fax: (907)456-4045

www.fairbankshearing.com

PEDIATRIC AUDIOLOGICAL CASE HISTORY

Child's Name: _____ DOB: ____/____/____

Mother's Name: _____ Father's Name: _____ Referral Source: _____

HEARING HISTORY:

Have you ever questioned your child's ability to hear normally? YES NO

If yes, please describe: _____

How long have you noticed this problem? _____

Has your child's hearing been tested before? YES NO

If yes: Where? _____ When? _____

Do any of the child's relatives have hearing problems? YES NO

If yes: Who? _____ What age was the loss identified? _____

Has your child received any medical treatment for their ears (i.e. tubes)? YES NO

If yes, please describe: _____

Please check all hearing-related health observations that apply to your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Tugging on ear | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Complaining of ringing in ears | <input type="checkbox"/> Clumsiness/Off balance | <input type="checkbox"/> Noise exposure |

BIRTH HISTORY:

Age of mother at birth: _____ Length of pregnancy: _____ Birth Weight: _____

What were the results of the child's newborn hearing screening? PASS FAIL UNKNOWN

Please check any of the conditions that occurred during or after pregnancy:

- | | | |
|--|--|---|
| <input type="checkbox"/> Maternal Substance abuse | <input type="checkbox"/> Caesarean | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Maternal Alcohol abuse | <input type="checkbox"/> In-utero Infections | <input type="checkbox"/> NICU stay >5 days |
| <input type="checkbox"/> Lack of oxygen/Oxygen given | <input type="checkbox"/> Communicable diseases | <input type="checkbox"/> Congenital defects |
| <input type="checkbox"/> Maternal X-rays/illness | <input type="checkbox"/> Medication given to child | <input type="checkbox"/> Childhood head trauma/concussion |

OVERALL DEVELOPMENT:

(i.e. antibiotics)

How do you feel your child's speech, language and basic communication skills are developing? _____

Is your child currently in speech, occupational or physical therapy? YES NO

When did he/she speak their first words? _____

Does your child understand what you say to him/her? YES NO

Do you have any additional concerns or questions about your child's hearing, communication skills or overall development?

