ONSLOW AMBULATROY SERVICES
ONSLOW EAR NOSE & THROAT

55 OFFICE PARK DRIVE I JACKSONVILLE, NC 28456
PHONE: 910.219.3377 FAX: 910.577.4983

AUDIOLOGY Pediatric Case History

Please complete this form. Attach copies of any child additional information or reports that might assist us in our evaluation. Any information regarding your child will be handled in a confidential and secure manner.

Child's name: ____ Age: __________ □Male □Female
First Middle Last

Address:____
Street/PO Box City State Zip Code

Child's School:____ Grade:_______________

Referred by: ____

A. Auditory and Hearing Information

1. Did your child pass his/her new born hearing screening? □YES □NO
2. Do you feel your child has a hearing problem? If so, why? ______________________________
3. When was the hearing problem first noticed? ___________________________________
4. Does your child have a history of ear infections? _______________________________
   i. If yes, when was the most recent ear infection? __________________________
5. Describe any previous treatment or testing your child has received his/her ears or hearing:
   ____
6. Has your child been exposed to a loud noise or explosion? ___________________________
7. Does your child ever complain about fullness or noise in the ears? _____________________
8. Does your child seem to watch a speaker's face closely for cues as to what is being said? __________
9. Does your child respond to the following?
   His/her name ____ Loud Noises _____ Soft Noises ______ Verbal Commands ______ Vibrations ____
10. Check any of the following additional services, which your child has received.
    □Speech / language evaluation or therapy □Academic tutoring □Occupational therapy
    □Psychological testing □Special Education □Genetic evaluation
    □Neurological evaluation □Physical therapy □Auditory processing evaluation
11. Does any member of your family have a hearing problem and/or wear a hearing aid? □YES □ NO

If so, please describe ____

B. Pre-Natal History

□ Rh incompatibility	□ Substance abuse	□ Alcohol abuse
□ CMV	□ Lack of oxygen	□ Maternal X-rays/illness
□ Rubella / German measles	□ Infections	□ Toxemia
□ Communicable disease	□ Medication	□ Venereal disease

C. Pregnancy and Birth Information

1. Length of pregnancy: ___________________________________ months / weeks

2. Length of labor: _______________________________________ hours

3. Child's birth weight _______________ lbs. _________________ oz.

4. Check any of the following which apply:

□ Breech	□ Planned C-section	□ Trouble breathing / Required oxygen
□ Incubator used	□ Emergency C-section	□ Jaundice
□ Instruments used	□ Low APGAR scores	□ Congenital defects
□ Discoloration	□ Other _______________________________________	

5. Was your child in Neonatal Intensive Care Unit? □YES □NO
   If, yes for what reason?_________________________________ For how long? __________________________

D. Developmental information

1. Child's physical development has been __________________________________ (fast, slow, normal)

2. Which hand does your child prefer to use? ____

E. Medical Information

1. Check the illnesses or conditions that your child has or has had in the past

□ Coordination problems	□ Feeding difficulties	□ Dizziness
□ Swallowing difficulties	□ Convulsions /seizures	□ Eye problems
□ Serious accident(s)	□ Allergies	□ Flu
□ Surgery	□ High fevers	□ Concussion
□ Recurrent headaches	□ Tonsillitis	□ Encephalitis
□ Chick pox	□ Measles	□ Skull Fracture
□ Meningitis	□ Frequent colds	□ Sinusitis
□ Attention deficit disorder	□ Down syndrome	
□ Cerebral palsy	□ Cognitive delays	

Other: ____

F. Speech and Language Information

1. Have you had any concern regarding your child's speech and language development? ______________________
2. Did your child smile and cry appropriately as an infant? □YES □NO
3. At what age did your child do the following: Babble ____________Use words ____________Use phrases ______
4. Do any family members have speech difficulties? □YES □NO If yes, please describe. ______________________
5. Is your child aware of his/her communication problem? ____
6. How do you communicate with your child? ____
7. Can your child follow simple verbal instructions? ____
8. How does your child make his/her needs known to you? ____
9. Check any of the following that apply to your child and/or list other : __________________________________

□ Poor listening comprehension	□ Repeats or hesitates when talking
□ Leaves out words	□ Uses incorrect or immature grammar
□ Reverse words order	□ Talks too rapidly or too slowly
□ Uses gestures rather than speech	□ Talks very little
□ Pronounces sounds incorrectly	□ Difficulty maintaining eye contact

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G. Behavioral Information

Check any of the following that relate to your child's behavior:

□Demands attention	□ Under unusual stress at home	□ Impulsive
□ Easily frustrated	□ Lacks confidence	□ Withdrawn
□ Short attention span	□ Talks excessively	□ Nervous or sensitive
□ Easily distracted	□ Tires easily	□ Makes inappropriate comments
□ Hyperactive	□ Overly sensitive to loud noises	□ Lacks motivation
□ Cries easily	□ Confused in noisy places	□ Underachiever
□ Slow learner	□ Prefers to play alone	□ Daydreams

H. Educational Information

1. Has your child ever repeated a grade? ____________ If so, which grade and why? ___________________________
2. Has your child ever received any special help at school? ______________ if so, describe. ____________________

   ____
3. Does your child like school? □YES □NO ____
4. Has your child been a behavioral problem at school? □YES □NO If so, describe ________________________
5. Have any of your child's teachers ever requested that his/her hearing or vision be tested? ____________________
6. Does your child have problems paying attention or following directions in the classroom?___________________
7. Is there any history of learning problems in your family? ____

8. Please describe any additional information about your child's behavior, schooling, health, etc., which you feel, is important.

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Signature of person completing the form **Relationship to patient** **Date**