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Rebecca A. Price, AuD

BRC Family Hearing Solutions

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Pediatric Case History Form

Patient Name:___________________________ DOB ___________Today's Date_________
Parent(s) Name: Mother__________________________ Father__________________________________
1. What is your concern today? ____
2. How did you hear about BRC Family Hearing Solutions? ______________________________________
Referral Source:____
3. Length of pregnancy: ______________weeks Birth weight _____lbs_______Oz.
4. Hospital of delivery____
5. Type of delivery_______________________________ Was labor induced? Yes___ No__
6. Did your child spend any time in the NICU? Yes__ No___ If yes, How long?________________________
7. Any complications during pregnancy or delivery? Yes__ No___ If so, please explain:____
____
8. Was there a history of drug use or STD during pregnancy? Yes__ No__ If yes, please explain____
9. Did your child pass the newborn hearing screening? Yes__ No__ If no, what ear? Right__ Left__ Both___
10. Are there any concerns about your child's hearing? Yes__ No___ If yes, please explain____
____
11. Is there any family history of hearing loss occurring before the age of 30 years? Yes__ No___
Relationship:____
12. Does your child currently wear hearing aids or use an auditory trainer? Yes__ No_____
13. Do you have any concerns about your child's speech and language? Yes__ No__ if yes, please explain
____
14. Is your child currently receiving speech therapy? Yes__ No___
15. Do you have any medical concerns about your child? Yes__ No__ Explain ___________
____
16. 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/injury____ Chicken pox____
Allergies____Noise exposure (e.g. farm equipment, loud music) _____ Asthma_____
17. Is your child on any medications? Please list_____________________________________
18. Do you have any other concerns about your child? Yes__No__
Explain____
19. Does your child:
a. Play/interact well with other children? Yes__ No__
b. Have attention/concentration difficulties? Yes__ No__
c. Receive any special education services? Yes__ No__
d. Have difficulty in school? Yes__ No__

Name of school____ Grade___ Teacher____________

____

Parent or Guardian's Signature Relationship Date