

## 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:

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ear surgery	<input type="checkbox"/> Measles
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Head trauma/injury
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Noise exposure (e.g., farm equipment, loud music)	

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have attention/concentration difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Receive any special education services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have difficulty in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of school \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_