Hear 4 KiDz

CASE HISTORY

I. GENERAL INFORMATION

PATIENT'S NAME _____ Date of Birth:_____
ADDRESS:_____CITY:_____ZIP:_____
HOME PHONE:_____OTHER PHONE: _____
PARENT'S NAME:_____ Date of Birth:_____
Referral Source: _____
Patient's Doctor/Pediatrician: _____
What is your concern that brought you here today?

_____
_____
List any current diagnosis's that your child has:

_____
_____

II. BIRTH HISTORY

Health of mother during the pregnancy _____
Length of the pregnancy: Premature _____ Full Term _____
Medication during pregnancy? Yes _____ No _____ if yes, reason and type

_____
Type of delivery: _____
Complications of delivery? _____

III. HEARING HISTORY

Has your child ever had ear infections? When? _____
How was it treated? _____
Was your child seen by an ENT doctor? YES _____ NO _____
If YES, which doctor?

_____
Do you think that your child has a hearing loss? _____
If yes:
What makes you feel this way? _____
Please check the illness that your child has had/had been treated for:

measles	chicken pox	mumps	scarlet fever
encelphalitis	seizures	meningitis	rubella

other _____

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IV. SPECIAL TESTS

Has your child ever been given:
Speech/language Evaluation? When _____ Where _____
Psychological Test? When _____ Where _____
Neurological Test? When _____ Where _____
Therapy? When _____ Where _____

V. EDUCATIONAL HISTORY

Is your child enrolled in school?
Name of School_____
Grade _____
How is your child's academic performance?

_____
_____

What information would you like to obtain today?

_____
_____
_____
_____

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