Eagle Hearing

208-939-9359
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PEDIATRIC CASE HISTORY

Patient Name: **Birth Date:**
Address:
City: **State:** **Zip Code:**

Person completing the form: **Relationship to the patient:**

Home and family information:
1st Parent/Guardian's Name: 2nd Parent/Guardian's Name:
Child lives with:
Languages Spoken at home:

Please complete the following*:*
Child's Primary physician:____

Who referred your child: ____

What is the primary reason for your child's visit today? Please explain in detail.

HEARING HISTORY:
Yes No Does your child complain of noise in the ears or head?
Yes No Does your child have dizziness or imbalance?
Yes No Did your child have hearing screening as a newborn? Results?

Yes No History of ear infections? Approximately how many at what ages? When was the most recent infection?

Yes No Does your child currently have ventilation tubes?
Yes No Does your child report pain in the ears?
Yes No Has any drainage from the ear been noticed?
Yes No History of ear surgery? If so, please explain what was completed and the dates.

Yes No Has your child ever worn hearing aids?

CHILD'S MEDICAL HISTORY:
List any serious illnesses, injuries, hospitalizations, or other surgeries?

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Yes No Does your child frequently breath with the mouth instead of the nose?
Yes No Does your child snore?
Yes No Does your child experience sinus pressure or pain?
Yes No Does your child experience acid reflex frequently?
Yes No Does your child experience allergies?

Indicate any of the following that are applicable to pregnancy and birth history:

Yes No Prenatal problems
Yes No Premature birth
Yes No Blood incompatibility
Yes No Birth weight of less than 3.3 lbs
Yes No In utero infection
Yes No Ototoxic medications
Yes No Bacterial meningitis
Yes No Elevated bilirubin
Yes No Apgar score of 0 to 4 at 1 minute or 0 to 6 at 5 minutes after birth
Other?

Indicate any diagnosis your child has received:

Yes No Hearing loss
Yes No Attention deficit disorder (ADD or ADHD)
Yes No Speech/Language disorder
Yes No Developmental or delayed
Yes No Pervasive developmental disorder (PDD) or autism
Yes No Cerebral palsy or a motor coordination disorder
Yes No Emotional or psychiatric disorder
Other?

Current medications, dosage, and reason:

Have any other specialists seen your child?

Yes No Speech-language pathologist
Yes No Psychologist
Yes No Developmental pediatrics specialist
Yes No Special education specialist
Yes No Physical therapist
Other?

Signature ________________________________ Date ________________