# Hearing Health Services

**20 NW Birch Street**
**Coupeville, WA 98239**

## Pediatric Case History:

Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child's everyday level of functioning. Please try to give additional comments where appropriate.

Date Completed: _____ By: _____ ☐ Mother ☐ Father ☐ Guardian

Child's Legal Name: _____ Nickname _____ DOB: _____

Reason for Visit: _____

_____

Child lives with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Does your child have any medical conditions? ☐ NO ☐ YES - please explain below:

_____

Was a Newborn Hearing Screening completed? ☐ NO ☐ YES If yes, ☐ PASS or ☐ FAIL/REFER

When and where did the screening take place:

_____

Any additional hearing testing completed: _____

Where there any complications with pregnancy and/or delivery? If yes, please explain. ☐ NO ☐ YES

_____

During pregnancy, did the mother: ☐ drink alcohol ☐ use tobacco ☐ use recreational drugs

If so, detail frequency and consumption: _____

Does your child's development seem normal to you? ☐ NO ☐ YES To others? ☐ NO ☐ YES

Does your child: ☐ Consistently respond to sounds ☐ Turn towards a sound source ☐ Enjoy Music

☐ Startle to loud noise ☐ Respond to his/her name ☐ Respond to sounds coming from other rooms

Do you have any concerns about your child's hearing? ☐ NO ☐ YES If yes, explain:

_____

_____

Does anyone in your family (immediate & extended) have hearing loss that began before age 30?

☐ NO ☐ YES If yes, please explain: _____

_____

*The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign this notice, this practice is not obligated to treat the patient.*

Please list your child's current medications, vitamins or other OTC (over-the-counter) supplements:

_____

_____

Allergies (food, medications, latex etc.) _____

Has your child had any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ Ear Infections | ☐ Ear Surgery | ☐ Hospitalizations | ☐ Head trauma/injury | ☐ Meningitis |
| ☐ Diabetes | ☐ Tonsillectomy | ☐ Adenoidectomy | ☐ Noise exposure | ☐ Seizures |
| ☐ Kidney Problems | ☐ Vision Problems | ☐ High Fevers | | |

Comments related to any other concerns you would like to discuss today:

_____

_____

_____

_____

_____

_____

**Name of Parent/Guardian**

_____

**Signature of Parent/Guardian**

_____

**Date**

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