Albuquerque **Speech Language Hearing** Center

Be a part of the conversation.℠

AUDIOLOGY CHILD CASE HISTORY

Patient Name: _____ Date of Birth: _____

Audiologist: _____ Date of Visit: _____

1. Do you think your child has a hearing problem? Yes ____ No ____
   a. If yes, which ear*?* Right ____ Left ____ Both ____ Unsure ____
   b. If yes, was the hearing loss gradual or sudden? Gradual ____ Sudden ____

2. Is there a family history of hearing loss (mother or father)? Yes ____ No ____
   a. If yes, do you know what caused the loss? Yes ____ No ____
   b. If yes, explain: _____

3. Has your child seen a doctor regarding their ears/hearing loss? Yes ____ No ____
   a. If yes, what kind of doctor?: Primary Care ____ ENT Specialist ____

4. Was the pregnancy of this child normal? Yes ____ No ____
   a. If no, please explain any complications: _____

5. Was the delivery of this child normal? Yes ____ No ____
   a. If no, please explain any complications: _____

6. Did your child pass their newborn infant hearing screening at birth? Yes ____ No ____

7. Do you believe your child's speech and language is developing normally for his or her age? Yes ____ No ____

8. Do you believe your child is physically developing normally? Yes ____ No ____

9. Does your child go to school or a daycare center? Yes ____ No ____

10. Does your child require special service, such as speech therapy or remedial academic help? Yes ____ No ____
    a. If yes, please explain_____

11. Does your child ever complain of:
    a. Ear pain? Yes ____ No ____
    b. Tinnitus (ear noises)? Yes ____ No ____
    c. Dizziness? Yes ____ No ____

12. Has your child experienced ear infections? Yes ____ No ____
    a. If yes, when was the most recent ear infection? Date _____

T 505.247.4224 **F** 505.247.1772 9500 Montgomery NE, Suite 215 Albuquerque, New Mexico 87111

13. Has your child ever had ear surgery? Yes ____ No ____

14. Has your child ever worn hearing aids? Yes ____ No ____

15. Has your child ever been exposed to very loud sounds? Yes ____ No ____
    a. If yes, did they wear hearing protection? Yes ____ No ____

16. Has your child had their hearing tested since their newborn screening? Yes ____ No ____
    a. If yes, please list the name and address of clinic/audiologist:
    Name: _____
    Address: _____
    Date of last hearing test & results: _____

17. Is your child scheduled to see an ENT? Yes ____ No ____
    a. If yes, please list Ear, Nose and Throat specialist and appointment date:
    Name _____ Date _____

18. List any medications your child takes regularly: _____
    _____
    _____

19. Check any current or past illnesses. If yes, please include a brief description of the illness (i.e. your child's age at the time, mild or severe).
    Apnea _____ If yes, explain: _____
    Chicken Pox _____ If yes, explain: _____
    Encephalitis _____ If yes, explain: _____
    Meningitis _____ If yes, explain: _____
    Mumps _____ If yes, explain: _____
    Measles _____ If yes, explain: _____
    Accident _____ If yes, explain: _____
    Diabetes _____ If yes, explain: _____
    Seizures _____ If yes, explain: _____
    Head Injury or Stroke _____ If yes, explain: _____
    Genetic Disorder/Syndrome _____ If yes, explain: _____
    Other_____
    _____

20. Is there any additional information you would like to share? _____
    _____
    _____
    _____

21. How did you hear about us? _____

22. What is your e-mail address? _____

I verify that this information is complete and accurate.

_____ _____
Signature of Patient (or Parent/Guardian) Date of Birth

_____ _____
Name of Patient (Printed) Today's Date