CASE HISTORY: CHILDREN AUDIOLOGY

The following information is for professional use and will be handled confidentially.
This information will assist the audiologist in completing your child's evaluation.

Today's Date: _____
Patient Name: _____ Nickname (s) _____
Patient Date of Birth: _____
Address: _____
City: _____ State: _____Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Gender (Circle One): Male Female
Grade in School: _____
Name of School: _____
School Address & Phone: _____
Parent/Caregiver's Name: _____
How did you hear about us? (Circle One):
Newspaper Other Advertisement Insurance Company Internet Other: _____
Who may we thank for referring you to our office today?
Friend: _____
Referred by (Doctor): _____
Doctor's Address & Phone: _____
Person Responsible for Payment: _____
Name of person completing this form _____

Relationship to this child _____

<u>Sibling Information</u>
Name _____ Age____ Male____ Female____

Name _____ Age____ Male____ Female____

Name _____ Age____ Male____ Female____

Primary Language _____ Language spoken in the home_____

What language does the child speak? _____

HISTORY OF HEARING PROBLEM/MEDICAL DIAGNOSIS:

Age of onset: _____ Conditions of onset:

What attempts have been made to treat this problem?

When? _____ Results of this treatment?

Describe any circumstances that change the symptoms:

Do you consider this problem mild, moderate, or severe (Circle one) or other (Explain):

Is this problem interfering with your child's educational, social or vocational plans? Please explain if you answered "yes":_____

Do people have difficulty understanding your child when they talk to them?

If so, do you know why?

Has your child ever "lost their voice?" _____. If yes, describe circumstances and duration
_____
_____
_____

MEDICAL HISTORY:

Personal physician: _____
Others: _____
Was your child late to talk or walk? _____ at what age: _____
Does your child have any speech, language or swallowing problems?
_____
Any history of: excessive colds _____, allergies _____, sinus trouble _____
asthma _____, sore throats _____, upper respiratory infections _____
pneumonia _____, laryngitis _____, thyroid problems _____, swallowing
difficulties _____, wet vocal quality after eating/drinking _____.

Please list below all illnesses, injuries and operations (age and complications):
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
Tonsils and adenoids in _____ out _____

List all present physical disabilities:
_____

Current medications: _____
_____
_____

Estimate of your child's current physical health:
_____

Has your child's vision ever been tested? _____ Do they wear glasses? _____

Has your child's hearing ever been tested? _____ Do they wear a hearing aid? _____
Do you think they may have a hearing problem?
_____

SCHOOL HISTORY:

Educational Level:
Elementary _____ Junior High _____ Senior High _____
College _____Degree _____ Vocational _____ Other _____

SOCIAL HISTORY:

Hobbies/Sports: _____

Leisure time activities:_____

Group memberships:_____

FAMILY HISTORY:

Is there any family history of chronic illness, allergies, speech problems, hearing problems, swallowing problems, or other conditions? Please list all and describe conditions.

_____
_____

Additional Comments: