Pediatric Case History Form

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Appointment Date:

Child's Name: Preferred Name:

Address
Street City State Zip

Home Phone: Cell Phone:

Date of Birth: Age: Gender: ☐ Male ☐ Female

Primary Language: Social Security Number:

Email Address

Other Children in the family and their ages:

Was the child adopted? ☐ Yes ☐ No

If yes, from what country:

Age of child when adopted:

Family Physician Date last seen

Reason for visit

Reason for today's visit (your concern):

Father's information

Full Name: DOB:

Place of Employment

Business Address

Business Phone

Position

Social Security Number

Military Branch Years Served

Mother's information

Full Name: DOB:

Place of Employment

Business Address

Business Phone

Position

Social Security Number

Military Branch Years Served

Who has legal custody of this child
(Name) (Relationship)

(Address) (Phone)

Insurance Information - Please give you insurance cards to our front office staff so we can make a copy for our records.

Type of Insurance Member ID #

Insured's name Relationship to Patient

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Birth History

Age of mother during pregnancy: _____ years Length of pregnancy: _____ weeks

Did the mother experience any complications during pregnancy, labor or delivery, including illnesses, conditions, accidents, etc.: ☐ Yes ☐ No

If yes, please describe: _____

Was labor: ☐ Spontaneous ☐ Induced ☐ Cesarean

Length of labor: _____ hours

Did the mother use tobacco or smoke during pregnancy? ☐ Yes ☐ No

If yes, number of cigarettes/uses per day: _____

Did the mother drink alcoholic beverages (more than one drink per week) during pregnancy?: ☐ Yes ☐ No

If yes, what was the frequency and amount consumed: _____

Did the mother use recreational drugs during pregnancy?: ☐ Yes ☐ No

If yes, what drugs and how often: _____

Did the mother take any other medications during pregnancy (other than vitamins)?: ☐ Yes ☐ No

If yes, what drugs and for what condition(s): _____

Child's birth weight: _____

At birth, did the baby suffer from or experience any of the following complications (please check all that apply):

- ☐ Jaundice
- ☐ Breech birth
- ☐ Low birth weight
- ☐ Blue color
- ☐ Breathing/respiratory difficulties
- ☐ Premature birth
- ☐ Low APGAR score
- ☐ Infection of baby or mother
- ☐ Cesarean birth
- ☐ Sucking/swallowing difficulties
- ☐ Induced Labor

Did your child pass their Newborn Hearing Screening? ☐ Yes ☐ No

Any other conditions or complications at birth: _____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:

Allergies (food, medications, plastics, etc.):

Has the child experienced any of the following major medical conditions (please check all that apply):

- ☐ AIDS/HIV
- ☐ Appetite Change
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Influenza
- ☐ Malaise
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Typhoid
- ☐ Vascular Problems
- ☐ Other:

Please Check all medical symptoms that apply:

- ☐ Eye Problems (such as blurred vision, pain):
- ☐ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain):
- ☐ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations):
- ☐ Respiratory Symptoms (such as shortness of breath, cough, wheezing):
- ☐ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain):
- ☐ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma):
- ☐ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness):
- ☐ Psychiatric Issues (such as depression, anxiety, compulsions):
- ☐ Endocrine Symptoms (such as frequent urination, hot flashes):
- ☐ Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands):
- ☐ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency):

Additional Comments:

Has the child been immunized? ☐ Yes ☐ No

If yes, for which of the following (please check all that apply) :

- ☐ Anthrax
- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib
- ☐ Human Papillomavirus
- ☐ Influenze
- ☐ Measles
- ☐ Meningococcus
- ☐ Mumps
- ☐ Pertussis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rabies
- ☐ Rotavirus
- ☐ Rubella
- ☐ Smallpox
- ☐ Tetanus
- ☐ Zoster

Audiologic History

How does the child respond to spoken directions or questions?

Does the child respond to loud noise? ☐ Yes ☐ No

Please describe the noise:

Has the child ever had a hearing test? ☐ Yes ☐ No If so, when?

Does the child experience hearing loss? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both

If he/she does experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the child's hearing loss?

What do you think is the cause of the child's hearing loss?

Does the child have a history of ear infections? ☐ Yes ☐ No

If Yes: First occurrence: Frequency:

Most recent: Treatment(s):

Has the child ever had ear tubes surgically inserted? ☐ Yes ☐ No

If Yes, when:

Has the child ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears

Please check all medical conditions that apply:

- ☐ Dizziness or Unsteadiness — *If checked, is it accompanied by:* ☐ *Vomiting* ☐ *Nausea* ☐ *Ear Noises*
- ☐ Ear Deformity — *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Ear Drainage — *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Ear Pain/Earaches — *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Family History of Hearing Loss — *If checked, who?*
- ☐ History of Ear Wax Buildup ☐ *Yes* ☐ *No*
- ☐ Tinnitus/Ringing/Noises in ears — *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears* *Frequency?*
- ☐ Other — *Please describe:*

Developmental and Educational History

Does the child's rate of development seem normal to you? ☐ Yes ☐ No

When did the child first:

Hold his/her head up alone: Crawl:

Sit alone without support: Babble:

Walk unattended: Feed themselves:

Become toilet trained: Begin to say single words:

Combine words into small sentences: Use more complete sentences:

Please describe the child's gross motor (running and jumping) and fine motor (coloring and writing) skills:

Has the child ever been diagnosed with, or treated for, any of the following:

Neurological problems ☐ Yes ☐ No

ADHD/ADD ☐ Yes ☐ No *If yes, what medication(s) are they currently taking?*:

Articulation/speech disorder ☐ Yes ☐ No

Learning Disability ☐ Yes ☐ No

Language Disorder ☐ Yes ☐ No

Physical Impairment(s) ☐ Yes ☐ No *If yes, please describe:*

Other (please specify):

Has your child undergone any of the below listed therapies?:

Speech/Language Therapy ☐ Yes ☐ No *If yes, please describe:*

Occupational Therapy ☐ Yes ☐ No *If yes, please describe:*

Physical Therapy ☐ Yes ☐ No *If yes, please describe:*

Vision Therapy ☐ Yes ☐ No *If yes, please describe:*

Other (please specify):

Please describe the child's social development and interactions:

Child's School:

Current Grade:

Is the child enrolled in a special classroom setting? ☐ Yes ☐ No

If yes, please describe:

Does their classroom have an FM system? ☐ Yes ☐ No *If yes,* ☐ Personal ☐ Classroom

Additional Comments:

Medication List

Please list all prescriptions, vitamins, and recreational medications

Medication	Dosage	Frequency	Administered

Policy

We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.

Initials

Insurance Authorization

I request that payment of authorized benefits be made on my behalf to Better Sound Audiology for services furnished to me by the provider. I authorize any holder of medical information about me to release to Better Sound Audiology any information needed to determine these benefits or the benefits payable for related services.

Initials

Authorization to Release Medical Records

I hereby authorize you to release to my attorney(s), and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.

Initials

Notice of Privacy Practices / Acknowledgement of Receipt

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Better Sound Audiology & Hearing Aid service a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Initials

Signature of person completing this form

Relationship to child

Date