ADVANCED AUDIOLOGY

PEDIATRIC EAR and HEARING CASE HISTORY

Please CHECK YES/NO COLUMN for all that apply:

Concerns:	YES	NO		Does your child:	YES	NO
Ear Problems/Hearing loss (pain/infections/ear wax)			if yes →	Respond when called from another room?		
				Look to a sound source?		
Family history of hearing loss						
Speech and Language Concerns/Delay			if yes →	Do you have concerns with how your child talks?		
Has your child received Pressure Equalization Tubes ("ear tubes")? If yes, when: _____				Has your child received speech/language evaluation?		
				Does your child attend or will they attend speech therapy?		
Does anyone in household/daycare smoke cigarettes?				Say at least 10 words?		
				Say 2 – 3 word sentences?		
				Speak clearly to the family?		

Please list/describe any general health concerns; pregnancy/birth history, disease/disorder, behavior concerns, dizziness, etc…your child has experienced in the past or currently experiences:

How many ear problems has your child experienced? (please circle)

0-2 2-4 4-6 6-8 10 or more

Does your child regularly experience:

_____Allergies _____Congested nose _____Runny nose

How are their sinuses today?

_____Clear _____Mostly Clear _____Mostly Congested _____Congested

How did you hear about Advanced Audiology?_____

Signature below verifies above information is accurate and authorizes Advanced Audiology to perform testing, care and management services relating to your child's hearing healthcare needs.

Child's Name: _____ Age/DOB:_____

Patient/Guardian Signature: _____ Date:_____

Relationship to patient: _____