WESTERN WASHINGTON UNIVERSITY

An equal opportunity university

Communication Sciences and Disorders

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Person completing form: _____ ***Relation to client:*** _____

_____
Signature ***Date***

AUDIOLOGY CLINIC: INFANT & CHILD CASE HISTORY FORM

(Birth to age twelve)

Client Name: _____ Age: ____ Date of Birth: _____
Parent/Guardian Name: _____
Referred by: _____

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1. Reason for visit: _____

2. Do you believe your child has a hearing problem? Yes No
   If YES, when did you first notice it? _____
   _____

3. Previous hearing evaluations? Yes No
   Where: _____
   When: _____
   What were the results? _____
   _____
   What were the recommendations? _____
   _____

4. How does he/she respond to sounds?
   Mark all that apply:
   - [] Startles to loud noises
   - [] Notices sounds at home (EX. Car, dog, doorbell)
   - [] Locates source of sounds
   - [] Hears you call from another room
   - [] Watches your face intently
   - [] Turns up the volume on the television.
   - [] Other_____

5. Do you have any family members that had hearing loss before age 50? Yes No
   If YES, what is their relationship to your child? _____

6. Was there anything unusual about the pregnancy? Yes No
(*EX. Maternal illness or infections such as CMV, measles, mumps, exposure to chemicals, drugs, radiation, pregnancy complications, etc*.)
   If YES, please specify: _____
   _____

7. Was there anything unusual about the delivery/birth process? Yes No
(*EX. long labor, forceps/assisted delivery, cesarean section, bleeding, premature membrane rupture, or any other complications*)
   If YES, please specify: _____
   _____

8. Were there any factors that put your child at a higher risk for hearing loss? Yes No
   If YES, check all that apply:
   - [] Family history of congenital or delayed onset childhood hearing loss
   - [] Low birthweight *(less than or equal to 1500 grams*)
   - [] Low Apgar score (*a score of 4 or less at one minute and 6 or less at five minutes after birth on five objective signs: hear rate, respiratory effort, muscle tone, response to catheter in nostril and color*)
   - [] Maternal substance abuse (*prescription or illicit drug use*)
   - [] Low Intrauterine Growth Rate (*IUGR less than or equal to 5%)*
   - [] Mechanical ventilation (*more than 5 days*)
   - [] Craniofacial or skeletal abnormalities (*obvious to slight malformations of the head, neck, mouth, ears, etc*.)
   - [] Cleft lip/palate
   - [] Hyperbilirubinemia aka. “Jaundice” (*excessive bilirubin levels requiring a blood exchange transfusion*)
   - [] Ototoxic medications for more than t days (*gentamycin, vancomycin, etc*.)
   - [] Intracranial belled and/or other CNS abnormality
   - [] Bacterial Meningitis
   - [] Congenital Perinatal Infections (*herpes, HIV, rubella, CMS, toxoplasmosis*)
   - [] Other: _____
     _____

9. Does he/she have a history of head trauma? Yes No
(*EX. Birth trauma, skull fracture, concussion, unconsciousness, etc*.)
   If YES, please describe, including dates and circumstances _____
   _____
   _____

10. Does he/she have a history of other health problems? Yes No
(*EX. diabetes, kidney, circulatory/heart, thyroid, infections, etc*.)
If YES, please describe: _____
_____

11. Is he/she currently take medications? Yes No
If YES, what medication(s)? _____
What reason(s)? _____

12. Does your child have a history of ear infections? Yes No
If YES, which ear? Right Left Both
At what age did they first occur? _____
How frequently did they occur? _____
What were the symptoms? _____
How have the infections been treated? _____
When was the last occurrence? _____
Comments: _____

13. Does your child have a history of dizziness? Yes No
If YES, how would you describe their dizziness? _____
_____
When did it start? _____
What brings it on? _____
How often does it occur? _____
Has medical consultation been obtained? Yes No
Comments: _____
_____

14. Are there any other developmental concerns? Yes No
If YES, please describe: _____
_____

15. Do you feel your child's speech and/or language is delayed? Yes No
If YES, please describe why: _____
_____

16. What are your greatest concerns regarding your child's hearing capabilities as they relate to daily activities, school, etc.? _____
_____
_____

OTHER PERTINENT INFORMATION: _____
_____