HEARING SOLUTIONS
PEDIATRIC CASE HISTORY

Child's Name _____ **Birth Hospital** _____
Date of Birth _____ **Birth Weight** _____
Discharge Date _____ **Gestational Age** _____

Mother's Name _____ **Father's Name** _____
Mother's Maiden Name _____ **Mother's DOB** _____
Birth Hospital _____ **Mother's Marital Status** _____
Mother's Education *(last grade completed)* _____ **Mother's Medicaid #** _____
Parity G: _____ **P**: _____ **Pre-Term**: _____ **AB:** Elective/Spontaneous **Prenatal Care** 1st 2nd 3rd

Y or N Latino/Hispanic
Primary Language_____ **Race** (1) White; (2) Black or African American; (3) American Indian or Alaska Native; (4) Asian; (5) Native Hawaiian or other Pacific Islander

Pediatrician's Name _____ **Address** _____
City _____ **Phone** _____ **Fax** _____

CHILD BIRTH HISTORY (circle Y or N)

Y or N Did mother have any of the following during pregnancy? (Circle all that apply)
CMV Toxoplasmosis Rubella Herpes

Y or N Hyperbilirubinemia
Y or N Phototherapy
Y or N Treated with blood transfusion
Y or N Breathing problems
Y or N Diuretics
Y or N Mechanical Ventilation # of days_____
Y or N Vaccines given during hospital stay
Y or N IV Antibiotics # of days _____
If baby was in NICU, how many days/weeks _____
List all medications taken during pregnancy, including use of alcohol and/or illicit drugs:
_____
Illnesses/Complications during pregnancy: _____

CHILDHOOD HISTORY (circle Y or N , explain if yes)

Y or N Did child pass newborn infant hearing screening? Don't Know
Y or N Has child's hearing been tested since birth? When? _____ Where? _____
Y or N Are you concerned about your child's hearing? _____
Y or N Do you have concern about your child's speech and language development? _____
Y or N Has your child been diagnosed with any illness or syndrome? _____
Y or N Had Meningitis? Bacterial or Viral
Y or N Diagnosed neuro-degenerative disorders? _____
Y or N Abnormalities of the face, head, skin, muscles, bones, kidneys, heart, eyes or system of the body? _____
Y or N Family history of hearing loss? List each and their relationship to child _____
_____
Y or N Does your child have diabetes or is there family history of diabetes in family?
Y or N Any surgeries or hospitalizations? (Describe) _____
Y or N Had PE Tubes? When? _____ Y or N Are tubes still in?
Y or N Sinus Problems? _____ Y or N Allergies? _____
Y or N History of ear infections: How many?_____ How have they been treated? _____
Y or N Does your child wear hearing aids? When was your child diagnosed with hearing loss? _____