Pediatric Case History (0-5)

Patient Information

Name: ____ Guardian: ______________________________________

Birthdate: __________________ Gender: Male Female Other

Primary Language: _________________ Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: _______________

Preferred Phone: Home Mobile Work

Address: ____ Home Phone: ____________________________

City: _______________________ State: ________ Zip Code: ___________ Mobile Phone: ___________________________

E-mail Address: ____ Work Phone: ____________________________

Student Status: ______________

Emergency Contact: _______________________Phone: _____________________Relationship: _____________________

Primary Care Physician: ____ Phone: _________________________________

Please list all the ways you heard about us: ____

Child lives with: Both Parents Mother Father Other___________

Names and ages of any other children at home:____

____

Name and Address of Child's School, Preschool, or Child Care Setting: ____

____

Reason for Visit

Chief Complaint: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both Dizziness/Vertigo

Auditory Processing Difficulties Failed Hearing Screening Other: _____________________

Medical History

Please circle if your child has had any of the following:

Allergies	Chicken Pox	Hospitalization	Mumps	Other: ______________
Asthma	Ear Infections	Head Trauma/Injury	Noise Exposure (Headphones, Loud music, hunting, etc.)	
Balance/gait/dizziness problems	Ear/Nose/Throat Surgery	Kidney Problems	Seizures	
Cerebral palsy	Eye/Vision Problems	Measle		
		Meningitis		

Is the patient on any prescription or over-the-counter medications? No Yes

If yes, please provide list at check-in.

Hearing History

Do you have any of the following concerns about your child's hearing? Select all that apply.

___ Does not respond to my voice

___ Does not react to loud noises

___ Does not search for or look towards where a sound is coming from

___ Does not seem to enjoy listening to music

___ Other: ____

Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?

No Yes   If YES, who? ____

Has your child had a hearing test? No Yes

If Yes, please list by whom, when and results: ____

Does your child wear hearing aid(s)? No Yes

If Yes, when was your child first fit? ____

Does your child receive preferential classroom seating or other accommodations? No Yes

If Yes, briefly explain: ____

Risk Factors:

Were labor and delivery abnormal in any way? Select all that apply.

___ Labor Induced

___ Labor less than 3 hours

___ Labor longer than 24 hours

___ Premature membrane rupture

___ Bleeding

___ Forceps delivery

___ Cesarean Section (C-section)

___ Other ____

At what week of the pregnancy (gestation) was the child born? ____

Did the mother experience any of the following during the pregnancy? Select all that apply and briefly explain.

___ Drugs taken during (including antibiotics) ____

___ Exposed to chemicals ____

___ Exposure to radiation/chemotherapy ____

___ Amniocentesis performed

___ Rh immunoglobulin given (Rh or ABO incompatible)

___ Illnesses ____

___ Anemia

___ Diabetes

___ Toxemia

___ Paternal illnesses ____

___ None of the Above

Was the Mother exposed to any of the following diseases during the pregnancy: Select all that apply.

___ Chickenpox

___ Measles

___ Mumps

___ German Measles

___ Other ____

Was the Mother diagnosed with any of the following infections during the pregnancy? Select all that apply.

___ Syphilis

___ Herpes

___ Influenza

___ HIV/AIDS

___ Cytomegalovirus (CMV)

___ Toxoplasmosis

___ Other ____

Did the Mother take any medications during the pregnancy? No Yes

If yes, please provide list at check-in.

Newborn Factors:

After birth, did your child have any of the following issues. Select all that apply and briefly explain.

___Breathing difficulties

___Required an incubator

___Any head, neck, or ear abnormalities

___Feeding problems

___Surgery

___Any infections requiring medication

___Treatment for jaundice
(yellow coloration of the skin)

___ Birth weight less than 5 pounds
(specify birth weight) _________

___ Poor weight gain

___ Stayed in hospital after mother went home

___ APGAR score low at birth (list score) __________

___ Placed in intensive care (specify how long) _______

___ Oxygen given at birth (specify how long) _________

___ Bilirubin > 15mg/100ml

___ Congenital rubella

___ Physical deformities (specify) __________________

___ High Fever

___ Defects of ear, nose, throat (specify) ____________

___ Congenital heart disease

___ Septicemia

___ Drugs given (inc. antibiotics, specify) ____________

___ Exposure to Chemicals (specify) ________________

___ Paralysis at birth

___ Seizures at birth

___ Did not pass hearing screening

___Other ______________________________________

___None of the above

Primary Insurance Information (If patient is also the insured, enter 'SAME' for name & address)

Insurance Company Name: ____

Insured's Name: _________________________Address: ____

Patient Relation to Insured (circle one) Self Spouse Child Other ____________

Subscriber ID Number (Member ID): ______________________Insurance Group Number: ______________________

Secondary Insurance Information (If patient is also the insured, enter 'SAME' for name & address)

Insurance Company Name: ____

Insured's Name: _________________________Address: ____

Patient Relation to Insured (circle one) Self Spouse Child Other ____________

Subscriber ID Number (Member ID): ______________________Insurance Group Number: ______________________

By signing below, I consent for my child to receive audiological services at All Generations Audiology, PLLC. The consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as my child receives audiological care at All Generations Audiology, PLLC.

Signature: ____ **Date:** ___________________________

Relationship if not signed by patient (i.e. guardian, POA, etc.) ____