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PEDIATRIC CASE HISTORY

Child's Name:_____ Age:_____

Date of Birth:_____ Gender (optional): Male or Female

In your own words, please describe the reason(s) for the child's appointment today:

_____
_____
_____
_____
_____

FAMILY HISTORY

Family history of kidney disease	YES	NO	History stillbirths\miscarriages	YES	NO
History of progressive blindness	YES	NO	Other children with hearing loss	YES	NO
History of thyroid problems	YES	NO	Family history of hearing loss	YES	NO
			If yes, who?_____		

Mother worked outside the home during pregnancy? YES NO
If yes, where and what type of work?_____

Father worked outside the home during pregnancy? YES NO
If yes, where and what type of work?_____

MATERNAL FACTORS

Drugs taken during pregnancy (including antibiotics) YES NO
If yes, specify:_____
Exposure to chemicals during pregnancy YES NO
If yes, specify:_____
Exposure to radiation/chemotherapy during pregnancy YES NO
If yes, specify:_____
Maternal Illness during pregnancy YES NO
If yes, specify:_____
Paternal Illness during pregnancy YES NO
If yes, specify:_____

Amniocentesis performed in pregnancy	YES	NO	Anemia during pregnancy	YES	NO
Rh immunoglobulin given	YES	NO	Diabetes during pregnancy	YES	NO
Rh or ABO incompatible	YES	NO	Toxemia during pregnancy	YES	NO

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MATERNAL FACTORS (CONTINUED)

Circle all that apply:

During Pregnancy, mother was exposed to: Chicken Pox Measles Influenza Mumps German Measles

During Pregnancy, mother was diagnosed with: Syphilis Herpes Influenza HIV\AIDs Toxoplasmosis Cytomegalovirus (CMV) Other:_____

DELIVERY AND LABOR FACTORS

Full Term Pregnancy	YES	NO	If no, how many weeks:_____		
Labor was induced	YES	NO	Premature membrane rupture	YES	NO
Labor was less than 3 hours	YES	NO	Forceps delivery	YES	NO
Labor was more than 24 hours	YES	NO	Cesarean section (C-Section)	YES	NO
Bleeding	YES	NO	Complications for Mother	YES	NO
Other unusual events	YES	NO	If yes, explain:_____		

NEWBORN FACTORS

Birth weight less than 5 pounds	YES	NO	If yes, specify birth weight:_____		
Placed in intensive care	YES	NO	If yes, how long?:_____		
Breathing problems at birth	YES	NO	Bilirubin > 15mg/100ml	YES	NO
Oxygen given at birth	YES	NO	If yes, how long?_____		
Congenital rubella	YES	NO	Paralysis at birth	YES	NO
Congenital heart disease	YES	NO	Seizures at birth	YES	NO
Drugs given at birth	YES	NO	If yes, specify:_____		
Longer than 2-4 day hospital stay	YES	NO	If yes, how long?_____		
Defects of ear, nose, or throat	YES	NO	If yes, specify:_____		
Pass newborn hearing screen?	**YES**	**NO**	**Hospital Born at:_____**		

INFANT and CHILDHOOD FACTORS

Eye problems	YES	NO	If yes, specify:_____		
Balance/gait/dizziness problems	YES	NO	Cerebral Palsy	YES	NO
Seizures	YES	NO	Head/skull injury	YES	NO

Is your child understood by:

Parents	YES	NO	Peers	YES	NO
Siblings	YES	NO	Strangers	YES	NO

Did you child do the following on time:

Roll	YES	NO	Walk	YES	NO
Sit Alone	YES	NO	Say first words	YES	NO
Crawl	YES	NO	Put 2-3 words together	YES	NO

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CHILD EVER HOSPITILIZED FOR / DIAGNOSED WITH / TREATED FOR:

Please circle all that apply:

Meningitis	Encephalitis	Measles	Influenza	Cytomegalovirus
Chicken Pox	Septicemia	Diabetes	Sickle Cell	Rubella
ADHD\ADD	Learning Disability	Cancer	Auditory Processing Disorder	
Speech or Language Disorder				

Please list any other hospitalizations, surgeries, or diagnosis':_____

_____

HISTORY OF EAR PROBLEMS

Ear Infections: NONE LEFT RIGHT BOTH

If yes, specify at what age and how many:_____

_____

When was there last ear infection?:_____

Tubes or Ear Surgery: NONE LEFT RIGHT BOTH

Has your child's hearing been tested before? YES NO UNSURE

If yes, where and when?_____

Does your child have an ENT Physician:_____

MEDICATIONS

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

DOCTORS

Primary Care: _____
Specialists: _____
_____

_____ _____ _____
Signature of the Person who Completed this Form | Relationship to Patient | Date Completed