E.N.T. PHYSICIANS OF KEARNEY
and Family Hearing Center

PEDIATRIC CASE HISTORY

Child's Name: _____ DOB: _____

Mother's Name: _____ Father's Name:_____

Pre-Natal History

Please check any of the conditions that occurred during pregnancy:

□ Rh incompatibility
□ CMV
□ Rubella/German Measles
□ Communicable Diseases
□ Substance Abuse
□ Lack of Oxygen
□ Infections
□ Medication
□ Alcohol Abuse
□ Maternal X-rays/illness
□ Toxemia
□ Venereal Disease

Birth History

Age of mother at birth: _____ Length of Pregnancy: _____
Child's weight at birth: _____ Apgar scores: _____

Please check any of the conditions that occurred during pregnancy:

□ Caesarean
□ Medication given to child
□ Jaundice
□ Lack of Oxygen
□ Congenital defects
□ Special Neonatal care or NICU
How long?_____
□ Oxygen administered-mother/child
□ Medication given to mother

If you checked any of the conditions above, please describe:_____
_____
_____

Child's Hearing History

Has your child had a medical or surgical treatment for their ears, such as PE tubes? □ Yes □ No
At what age?
Does he/she ever complain of pain or fullness in the ear? □ Yes □ No

Has your child ever described a noise in the ear? □ Yes □ No
Which Ear? □ Right □ Left □ Both
Does your child fall or lose balance easily? □ Yes □ No

Has your child been exposed to loud noises or an explosion? □ Yes □ No
Describe:
_____

Health History

Please check all that apply and list date of occurrence:

□ Measles	□ Tonsillitis	□ Chicken Pox
□ Allergies	□ Mumps	□ Frequent Colds
□ Scarlet Fever	□ Ear Infections	□ Meningitis
□ Sinusitis	□ Encephalitis	□ Draining Ears
□ Seizures	□ Flu	□ High Fevers
□ Head Injury		

Any serious illnesses/injuries or surgeries? _____ □ Yes □ No
List any medications that your child is currently taking:
_____
_____

Does your child have any open sores, bleeding, or drainage at this time? □ Yes □ No

Speech Language & Hearing Development

How do you feel your child's speech, language and basic communication skills are developing?
_____
_____
Is your child currently receiving speech, occupational, or physical therapy? □ Yes □ No

Is your child talking? □ Yes □ No If yes, when did they say their first words?_____

Does your child respond to your speech? □ Yes □ No

Have you ever questioned your child's ability to hear normally? □ Yes □ No
If yes, please describe: _____
How long have you noticed this problem? _____
Has your child's hearing been tested before? □ Yes □ No
If yes, when and where? _____
Do any of the child's relatives have a hearing problem? □ Yes □ No
If yes: Who, what age was the loss identified, and is there a known
cause?_____
_____
_____