

PINE TREE SOCIETY
149 Front Street, Bath, ME 04530

HEARING CASE HISTORY – CHILD 5+ years

GENERAL INFORMATION

Date _____

Name of Child _____ Age _____ Birthdate _____ Sex _____

Address _____

Pediatrician or family doctor _____ Telephone _____

Your telephone _____ If no phone, please list a phone number where you may be reached _____ Child's School and City _____

How did you hear about Pine Tree Society's audiology Department?

Describe the reason for today's hearing test: _____

Was your child's hearing tested before? _____ If so, where and when? _____

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FAMILY INFORMATION

Parent/Guardian _____ Relationship _____

Occupation _____ Place of Employment _____

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Occupation _____ Place of Employment _____

Other children in the family

Name	Age	Sex	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does anyone in the family have a hearing problem, wear a hearing aid, or had an operation on their ears? _____ Describe _____

Does the family speak any language other than English? _____

HEARING AND SPEECH INFORMATION

Does your child have a speech problem? _____ Describe _____

Has your child had any earaches, abscesses, ear infections, or other ear problems? _____ If so, please list physicians who treated the earaches, etc., at what age the problem occurred, and how often: _____

Explain any surgery that your child has had for his/her ears, including tonsillectomy, adenoidectomy, and tubes in ears: _____

When your child was very young, did he/she startle to loud noises? _____

Is your child easily distractible? _____

Does your child seem to have a short attention span? _____

BIRTH INFORMATION

Is your child adopted? _____ Length of pregnancy _____ Birthweight _____

Is there Rh incompatibility? _____ Was the mother exposed to German Measles during pregnancy? _____ Describe any diseases, injuries, or rashes during pregnancy. _____

Did the mother take any medication during pregnancy? _____

Did your child have any problems breathing at birth? Please explain. _____

Was your child given any medications at birth? _____ Please explain. _____

Were there any other complications during labor and/or delivery? _____

Please explain. _____

HEALTH INFORMATION

Has your child ever had a high fever over a long period of time? _____

If so, how long and at what age? _____

Describe any severe illnesses, surgery, or other medical problems that your child has had. _____

Describe any head injuries (concussion, skull fracture, etc.) that your child has had: _____

Has your child been exposed to very loud noise for a long period of time (chainsaw, target shooting, motorcycle, loud music, etc)? _____
If yes, please describe: _____

What diseases has your child had?

	Age	Comments
Meningitis	_____	_____
Pneumonia	_____	_____
Convulsions(Seizures)	_____	_____
Other	_____	_____

Is your child taking any medication now? _____ For What Reason _____

Does your child have any allergies? _____

General health of child? _____ Do you have any other concerns about your child's physical development? Please explain.

Does your child have a diagnosis of ADHD or Autism? _____ Please describe: _____

EDUCATIONAL INFORMATION

Is your child having any serious problems in school? _____ If yes, please explain

Please describe any additional information, which you feel should be reported _____

THANK YOU