PINE TREE SOCIETY
149 Front Street, Bath, ME 04530

HEARING CASE HISTORY – CHILD 2 to 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_____ 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?_____

Was your child's hearing screened at Birth? _____ If so which hospital? _____

FAMILY INFORMATION

Parent/Guardian _____ Relationship _____

Occupation _____Place of Employment _____

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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?_____

BIRTH INFORMATION

Is your child adopted?_____ Length of pregnancy_____Birthweight_____

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._____

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?_____

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?_____ 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:_____

_____

Does your child have trouble sitting still or have separation anxiety?_____ Please describe: _____

_____

_____

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

_____

_____

_____

_____

THANK YOU