BEVERLY HOSPITAL AUDIOLOGY DEPARTMENT
PEDIATRIC CASE HISTORY

Name _____DOB:_____
Primary Care Physician_____

Birth History:

Place of birth_____
Full term? _____ if no, how long was pregnancy_____

Risk Factors:

___ Congenital infection (TORCH)
___ Hyperbilirubinemea
___ Ototoxic Medications
___ Bacterial meningitis
___ APGAR less than 3 at 5 minutes
___ Prolonged Mechanical Ventilation
___Asphyxia
___ Blood Transfusion
___ Other
___Stigmata or syndrome
___Birth Weight less than 3 pounds

Medical History:

Check/circle the following that may apply:

___ Hearing screening performed at birth? Passed Referred
___ History of ear infections:
___ History of Tubes:
___ History of ear surgery:
___ History of allergy or sinus problems
___ Speech and Language Development:
ON TARGET DELAYED
___ Enrolled in Speech and Language Therapy?
___ Enrolled in early intervention?
___ Birth Weight_____
___ Please list any childhood diseases:
_____
___Please list all medications currently being taken:

Hearing loss:

Is it felt that the patient may have either a temporary or permanent hearing loss?

NO YES

How long have you noted the hearing loss?

_____DAYS _____WEEKS _____MONTHS _____YEARS

Has the hearing loss occurred gradually over time or suddenly?

Other information you may wish to share, including your primary concern in bringing your child in today**:**

Form completed by: Relationship to child: Date: