PEDIATRIC CASE HISTORY

DeSoto EYE & EAR

Name: _____
First *Middle* *Last*

Date of Birth: / / Age: Sex: ☐ M ☐ F
MM / DD/ YYYY

Reason for today's appointment: _____

Please mark all concerns you may have:

- ☐ Hearing loss
- ☐ Ear Pain
- ☐ Frequent ear infections
- ☐ Speech delay
- ☐ Developmental delay
- ☐ Other (please describe below)

If "yes" to any of the above, please explain:

_____

Has your child ever had their hearing tested? ☐ Yes ☐ No

If YES: Date of Test_____ Location_____What were the results? _____

Does your child wear hearing aids or use an auditory trainer? ☐ Yes ☐ No

Did your child pass his/her newborn hearing screening? ☐ Yes ☐ No

Was the pregnancy/delivery of this child abnormal in any way? ☐ Yes ☐ No

If yes, please explain

_____

Did your child have to stay in the NICU for any duration after birth? ☐ Yes ☐ No

Was there a history of drug use or STD during pregnancy? ☐ Yes ☐ No

Is there any family history of hearing loss? ☐ Yes ☐ No

Additional medical history: (check all that apply)

- ☐ Developmental delay
- ☐ High fevers
- ☐ Vision loss
- ☐ Neurological problems
- ☐ Surgeries
- ☐ Head Trauma/Injury
- ☐ Noise Exposure (e.g. loud music)
- ☐ Other (please describe below)

Please explain any of the above:

_____

Does your child:

Play/interact well with other children? ☐ Yes ☐ No

Have attention/concentration difficulties? ☐ Yes ☐ No

Receive any special education services? ☐ Yes ☐ No

Have difficulty in school? ☐ Yes ☐ No

What school does your child attend?

_____

Current Grade Primary Teacher

_____

Parent or Guardian's Signature Relationship Date

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