OSWEGO HEALTH | CENTER FOR AUDIOLOGY AND HEARING AIDS

Name: _____

Date of Birth: _____

Today's Date: _____

Child Case History Questionnaire

(0 - 11 Years)

Pediatrician Name & Location: _____

What are your main concerns? _____

Date & Location of last hearing examination: _____

Birth History Length of pregnancy: _____ Birth weight: _____

Describe any birth complications: _____

Risk factors *(Please select all that apply)*:

- ☐ Family History of Childhood Hearing Loss
- ☐ Congenital Perinatal Infection
- ☐ Anatomic Malformation (ears, head, or neck)
- ☐ Prematurity (≤ 37 weeks)
- ☐ Hyperbilirubinemia (i.e., jaundice requiring exchange transfusion)
- ☐ Bacterial Meningitis
- ☐ Severe Asphyxia (Apgar score of ≤ 5 at 5 minutes)
- ☐ Hydrocephalus
- ☐ History of ear infections or surgery (e.g., tubes)
- ☐ Ototoxic Drugs
- ☐ ECMO
- ☐ Pulmonary Hypertension
- ☐ Down's Syndrome
- ☐ CHARGE Association
- ☐ Head Trauma
- ☐ Unusual illnesses :_____
- ☐ Hospitalizations: _____

Development & Behavior *(Please select all that apply)*:

- ☐ Motor development delays (e.g., sitting, crawling, walking)
- ☐ Speech and language delays
- ☐ Difficulty following directions
- ☐ Pulls on ears
- ☐ Hears well all of the time
- ☐ Hears well only at select times
- ☐ Sensitive to environmental sounds
- ☐ Receiving services or enrolled in special educational programs. Describe: _____
  _____
- ☐ Has been seen by a specialist other than pediatrician. Describe: _____
  _____

Identify **medications** and any **additional information** about your child that is relevant:

_____

_____

_____