UNIVERSITY OF NORTH TEXAS
SPEECH AND HEARING CENTER

Child Case History—Audiology

Please fill out this form completely. Use NA for "not applicable," CR for "can't remember," and DK for "don't know."
Child's Name_____ Date_____
Date of Birth _____ Age_____ Sex_____ Phone: Home_(_____)_____
Parents _____ Work_(_____)_____
Address_____
City State Zip
School _____ Grade _____
Referred by_____

Chief complaint or reason for referral_____
_____

1. Has your child had a previous hearing evaluation? yes_____ no_____
   If so, when and what were the results?_____

2. Do you think your child has hearing loss? yes_____ no_____
   If so, in which ear? right_____ left_____ both_____ When did it begin?_____
   What caused the hearing loss? _____

3. Is there a family history of hearing loss? yes_____ no_____
   If so, who had hearing loss?_____
   What was the age it began?_____ What caused the hearing loss?_____

4. Are there any birth defects or abnormalities in other relatives? yes_____ no_____
   If so, describe _____

5. Was the pregnancy and delivery with this child normal? yes_____ no_____
   If not, what was the length of pregnancy? _____ What was birth weight? _____
   Describe maternal illnesses or complications _____
   Describe problems at birth _____

6. Has your child had ear infections? yes_____ no_____
   If so, in which ear? right_____ left_____ both_____ What age did they begin? _____
   Has your child had drainage? yes_____ no_____ How many infections has your child had? _____
   When was the last infection?_____
   What kind of treatment has your child had? _____

7. Has your child had surgery on his/her ears? yes_____ no_____
   If so, which ear? right_____ left_____ both_____
   What type of surgery did your child have? _____
   When and where was the surgery? _____

Please answer the questions on the reverse side of this form.

8. Check any listed diseases/symptoms your child has had.
High fever_____ frequent colds or sore throats_____ allergies_____
Childhood diseases _____ other_____

9. What medications does your child currently take? _____
_____

10. What age did first words occur? _____ What were first words? _____
When did sentences occur? _____
Check how your child communicates primarily now.
Single words _____ sentences _____ gestures _____

11. Do you understand most of what your child says? yes_____ no_____
Do strangers understand your child? yes_____ no_____
Do you think your child has a speech problem? yes_____ no_____

12. When did your child sit alone? _____ When did your child crawl? _____
When did your child walk? _____ Does your child seem well coordinated? yes_____ no_____

13. Does your child appear confused in noisy situations? yes_____ no_____
Is your child easily distractable? yes_____ no_____
Does your child have a short attention span? yes_____ no_____
Does your child ask to have directions repeated? yes_____ no_____

14. Does your child like school? yes_____ no_____
Has your child ever received special help at school? yes_____ no_____
Has your child ever had behavioral problems at school? yes_____ no_____
Have any teachers asked you to have your child's hearing tested? yes_____ no_____
Have any teachers asked you to have your child's vision tested? yes_____ no_____
Does your child seem to rely heavily on visual cues? yes_____ no_____

Additional comments:

_____
Signature

_____
Relationship (if other than the patient)

Please answer the questions on the reverse side of this form.