UNIVERSITY OF NEBRASKA
SPEECH-LANGUAGE AND HEARING CLINIC
253 Barkley Memorial Center
Lincoln, Nebraska

Case History - Pediatric - Audiology

To be completed by a parent or guardian
Throughout this form, if the question does not apply, please write N/A.

Date _____

Client's Name (Please Print) _____
Last First MI

Birthdate ____/____/____ Age: _____ Gender: ☐ Female ☐ Male
month day year

Height _____ Weight _____

Child lives with: ___ both parents ___ Mother ___ Father ___ other

Names and ages of any other children at home: _____

_____

Name and Address of Child's School, Preschool or Child Care Setting _____

_____

Hearing History

	Yes	No
1. Do you have any concerns about your child's hearing? If yes, briefly explain: _____	☐	☐
2. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?	☐	☐
3. Does anyone in your family have night blindness?	☐	☐
4. Does your child consistently respond to your voice?	☐	☐
5. Does your child respond to loud noises?	☐	☐
6. When sound is present or someone is speaking, does your child search to find where the sound is coming from?	☐	☐
7. Does your child respond to sounds from other rooms?	☐	☐
8. Does your child enjoy listening to music?	☐	☐
9. Has your child's hearing ever been tested? If yes, please list by whom, when and results: _____	☐	☐

_____

10. Does your child wear hearing aid(s)? ☐ ☐
    If yes, when was your child first fit? _____
11. Does your child use an auditory trainer? ☐ ☐
12. Does your child receive preferential classroom seating? ☐ ☐

Pregnancy And Birth History

	Yes	No
1. Was the pregnancy abnormal in any way?	☐	☐
2. Was the delivery abnormal in any way?	☐	☐
3. Was the delivery premature?	☐	☐
4. Did the mother have any illness during the pregnancy?	☐	☐
5. Did the mother take any medication during the pregnancy?	☐	☐
6. After birth, did your child have:		
Breathing difficulties?	☐	☐
Require an incubator?	☐	☐
Any head, neck or ear abnormalities?	☐	☐
Feeding problems?	☐	☐
Surgery?	☐	☐
Any infections requiring medication?	☐	☐
Treatment for jaundice (yellow coloration of the skin)?	☐	☐

If yes to any of the above, briefly explain: _____

_____

_____

Medical History

1. Do you have any medical concerns about your child? ☐ Yes ☐ No
   If yes, briefly explain: _____

   _____

2. Please check if your child has had any of the following:

Ear infections	☐	Meningitis	☐	Seizures	☐
Ear surgery	☐	Measles	☐	Kidney problems	☐
Hospitalization	☐	Mumps	☐	Vision problems	☐
Head trauma/injury	☐	Chicken pox	☐	Allergies	☐
Noise exposure (e.g. farm equipment, loud music)			☐	Asthma	☐

   Briefly explain any you checked: _____

   _____

   Other significant medical concerns: _____

   _____

3. Please list any prescription or over-the-counter medications your child is taking and for what reason(s): _____

   _____

Physical Development History

1. Do you have any concerns about your child's physical development? ☐ yes ☐ no
   If yes, briefly explain: _____

   _____

2. About what age did your child: hold his/her head erect _____
   sit unsupported _____ walk alone _____
3. At what age was toilet training completed? _____
4. Does he/she lose their balance or fall easily? ☐ yes ☐ no
5. Does he/she seem uncoordinated or clumsy? ☐ yes ☐ no

Speech and Language History

1. Do you have any concerns about your child's speech and language? ☐ yes ☐ no

   If yes, briefly explain: _____

   _____

2. About what age did your child: follow simple directions _____

   say his/her first word _____ put two words together _____
3. Did your child continue adding words after the first word? ☐ yes ☐ no
4. If your child is 2 years old or younger, how many words does he/she use? _____
5. Does your child often use gestures when communicating? ☐ yes ☐ no
6. Is your child's speech understood by:
   parents ☐ yes ☐ no siblings ☐ yes ☐ no other adults ☐ yes ☐ no
7. Has your child's speech ever been evaluated? ☐ yes ☐ no

   If yes, please list by whom, when and results: _____
8. Is your child currently receiving speech therapy? ☐ yes ☐ no

Additional History

1. Do you have any other concerns about your child? ☐ yes ☐ no

   If yes, briefly explain: _____

   _____

2. Does your child:
   play/interact well with other children? ☐ yes ☐ no
   have attention/concentration difficulties? ☐ yes ☐ no
   receive any special education services? ☐ yes ☐ no

   If yes to any of the above, briefly explain: _____

3. Do you feel that your child is having any difficulty in school? ☐ yes ☐ no

If yes, briefly explain: _____

_____

_____ _____

Signature of person completing form Date

_____

Relationship to patient

7/98