ASHLAND AUDIOLOGY
PROFESSIONAL HEARING CARE

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Pediatric Case History

Patient's Name: _____ **Date of Birth:** _____ **Today's Date**: _____

Primary Physician: _____ **Parents Names:** _____

Please check the reason(s) your child is here today

☐ Ear Drainage — Right Ear☐ Left Ear☐ Both Ears☐

☐ Ear Pain — Right Ear☐ Left Ear☐ Both Ears☐

☐ Ear Noises/Ringing in Ears — Right Ear☐ Left Ear☐ Both Ears☐ How Often? _____

☐ Ear Infections — Right Ear☐ Left Ear☐ Both Ears☐ When? _____

☐ Previous Ear Surgery — Right Ear☐ Left Ear☐ Both Ears☐ When? _____

☐ Unsteadiness or Dizziness — Accompanied by: Vomiting☐ Nausea☐ Ear Noises☐

☐ Speech & Language Concerns — Yes☐ No☐ **Describe**: _____

Were there any complications during pregnancy or birth? Yes☐ No☐

If yes, please explain _____

Hearing & Speech Development

Did your child pass their newborn hearing screening? Yes☐ No☐

Are you concerned about your child's hearing? Yes☐ No☐

Is there hearing loss in the immediate family? Yes☐ No☐

If yes, please list who_____

Audiologist's Notes: