

**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       | <b>Describe:</b> _____ |                  |

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:**