sonus hearing care professionals

SONUS PEDIATRIC CASE HISTORY

Patient: _____ **Date of Birth:** ___/___/___ **Age:** _____ **Date:** ___/___/___
Provider: _____
Person completing this form: _____
Relationship to patient: _____
What is the primary purpose of this hearing test?_____

HEARING HISTORY

Yes / No 1. Is a hearing loss suspected by anyone? If yes, whom? _____

Yes / No 2. Do you suspect a hearing loss? (If no, skip to questions #3)
- A. At what age did you begin to suspect a hearing loss? ___ months ___ years
- B. Does the hearing loss fluctuate? Yes / No

Yes / No 3. Does any family member have a hearing problem? Yes / No (If no, skip to question #4)
- A. How is this person related to the patient? _____
- B. What was the cause of the hearing loss? _____

Yes / No 4. Does the child respond to sounds? Check all that the child does respond to.
___ whisper ___ door slam ___ parent calling child's name ___ doorbell/phone

Yes / No 5. Does the child look in the direction a sound came from?

Yes / No 6. Do you have concerns about how the child talks? (If no, skip to question #7)
- A. Does the child say at least 10 words? Yes / No
- B. Does the child say 2-3 word sentences? Yes / No
- C. Can non-family members understand your child's speech? _____ Yes / No
- D. Does the child see a speech therapist? Yes / No

Yes / No 7. Has your child had a hearing test before? (If no, skip to question#8)
- A. When did this occur and where?_____
- B. What were the results? _____

Yes / No 8. Has the child ever tried or worn hearing aids? (If no, skip to question #9)
- A. Which ear? Right/Left/Both
- B. Since what age? _____
- C. Manufacturer: _____ Model: _____

PREGNANCY AND BIRTH

Yes / No 9. Were the parents' blood types compatible?

Yes / No 10. Was the delivery premature? If yes, length of pregnancy: _____ weeks

Yes / No 11. Were drugs taken during the pregnancy? What/when: _____

Yes / No 12. Does the mother or child have a history of infectious diseases? Check all that apply:
___ Rubella ___ Toxoplasmosis ___ Syphilis ___ Hepatitis B ___ Herpes
___ Fetal Alcohol Syndrome ___ Cytomegalovirus (CMG)

Yes / No 13. Was the delivery normal? If not, describe: _____

Yes / No 14. Was the infant's birth weight normal? If not what was the birth weight? _____

Yes / No 15. Was the child ever admitted to a neonatal intensive care unit?

Yes / No 16. Was the infant's condition (APGAR score) normal at birth?
If not, describe: _____

(continued on back)

MEDICAL HISTORY

Yes / No 17. Has the child had any of the following? Indicate the age it occurred:
___ chicken pox ___ measles ___ mumps ___ scarlet fever ___ meningitis
___ fever over 104 degrees ___ encephalitis ___ blood disease
Complications during the above? _____

Yes / No 18. Does the child have any other medical problems?
Describe: _____

Yes / No 19. Does the child take any medications? If yes, for what? _____

Yes / No 20. Does the child have a visual problem?

Yes / No 21. Does the child have difficulty chewing or swallowing?

Yes / No 22. Has the child's development differed from other children his/her age?
If so, how?_____

Yes / No 23. Has the child had frequent ear infections or middle ear fluid? How often? _____
A. How has this been treated? _____

Yes / No 24. Does the child have difficulty in school? If yes, describe _____
_____
_____