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Pediatric Case History (<16 yrs old)

Name: _____ Date of Birth: ____/____/____ Age: _____

What is the reason for your visit today? _____

When was this problem first noted? _____

Have you sought professional advice before? _____ If yes, who/where/when? _____

Pregnancy and Birth Information

- During pregnancy, did the mother have any accidents, illness or conditions such as herpes, CMV, syphilis, rubella, toxoplasmosis, or diabetes? If yes, please explain: _____
- During pregnancy, did the mother take any medications or drugs (including alcohol)? _____
- Was the child premature? _____ If yes, length of pregnancy: _____
- Was delivery normal? _____ What hospital was the child born at? _____
- What was the child's birth weight? _____ Apgar score? _____
- Did the child require oxygen? _____ Was the child jaundiced (yellow)? _____
- Were there any deformities noted at birth? (e.g. skin tags or pits near ears, cleft lip/palate) _____
- Did the child spend any time in the NICU (neonatal intensive care unit)? _____
- Any other important information about birth? _____
- Did the child pass the Universal Newborn Hearing Screening? _____

(TURN OVER)

Medical History and Health Information

- What is the condition of the child's health? Good Fair Poor
- Has the child suffered from ear infections? _____ If yes, how many? _____
- Have PE tubes been placed in the child's eardrums? _____
- Does the child have any speech or language delays? _____
- Does the child have balance problems? _____
- List all other medical problems (e.g. vision loss, kidney problems, syndromes, developmental delay)?

- Has the child ever been hospitalized? _____ If yes, please explain: _____

- Is there concern about the child's hearing? _____
If yes,
 Does the child alert to environmental sounds? (e.g. telephone, doorbell) _____
 Does the child respond to voices? _____
 Can the child locate sound sources? _____
- Does the child have a history of noise exposure (e.g. guns, power tools, lawn mower)? _____
- Is there a **family** history of hearing loss before the age of 30? _____
- Does the child experience tinnitus? (eg Ringing, buzzing) _____
- Medication list – please list all including dosage and frequency _____

- Has the child been diagnosed with Covid 19? _____ If yes, Date and duration _____

Educational History

- Does the child attend school? _____ If yes, what school & grade? _____
- Does the child have attention problems at school? _____ If yes, please explain: _____
- Has the child ever received speech-language or hearing services? _____
- Has the child received any other special help or assistance at school? _____ If yes, please explain:

- Has the child been evaluated for anything else? _____

Parent/Guardian Signature

Relationship to Child

DATE: ____/____/____