

## PEDIATRIC HISTORY OF HEARING LOSS

### Case History Form

Date	
Patient Name	
Patient DOB	
Informant(s)	
Interpreter Used	
Language Used	
Language at Home	

#### Reason for Visit:

- |  |  |
|--|--|
| <input type="checkbox"/> Failed Newborn Hearing Screening                            | <input type="checkbox"/> Chronic Ear Infection     |
| <input type="checkbox"/> Sibling with hearing loss or family history of hearing loss | <input type="checkbox"/> CI Pre-Eval               |
| <input type="checkbox"/> Child not developing speech or language                     | <input type="checkbox"/> School Screening Referral |
| <input type="checkbox"/> Transfer of Services  | <input type="checkbox"/> Other                     |

#### Hearing Aid/Cochlear Implant Used:

Device:

Left ear serial # \_\_\_\_\_ Right ear serial # \_\_\_\_\_

Date Fit: \_\_\_\_\_

Location of Fitting: \_\_\_\_\_

Hours of use per day: \_\_\_\_\_

FM use:    T-Coil    Ear Level Receivers    Sound Field Speaker

#### Prenatal History:

	Yes	No	Comments
Maternal virus/infection			
Maternal meds/drugs			
Maternal conditions			
Maternal complications			

**Birth History:**

Hospital Born At: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Newborn Hearing Screening: Pass / Fail

Comments: \_\_\_\_\_

Startle Response: Yes / No      Comments: \_\_\_\_\_

Length of Gestation: \_\_\_\_\_ months \_\_\_\_\_ weeks

Birth Weight: \_\_\_\_\_

NICU: Yes / No      Comments: \_\_\_\_\_

**Developmental History:**

Milestone	Age Accomplished	Comments
Sitting		
Walking		
Babbling		
Speaking/Signing 1 <sup>st</sup> word		
Balance Problems		
Behavior Problems		

**Medical History:**

	Yes	No	Comments
Childhood diseases/conditions			
Family Hx of Hearing Loss			
Siblings			
Syndrome			
High Fevers			
Seizures			
Surgeries			
Respiratory Problems			
Cardiac Problems			
Medications			
Otitis Media			
P.E. Tubes			

**Speech and Language Development (Estimate):**

Number of Vocabulary Words:

0-5   5-10   10-15   15-20   20-25   25-30   30-35   35-40   40-45   50-75   75-100   100+

Number of Words in a Sentence:

0   1-2   2-3   3-5   5+

**Private Therapy:**

Type	Administered by	Location	Frequency	Duration	Ind/Group
Speech					
Occupational					
Physical					
Early Start					

**Services Received at School:**

Type	Administered by	Contact #	Frequency	Duration	Ind/Group
Speech					
OT/PT					
Audiologist					
DHH					
RSP					
Interpreter					

**Education:**

Current Release on File: Yes / No

School: \_\_\_\_\_

District/SELPA: \_\_\_\_\_

Language Modality:

\_\_\_ Oral

\_\_\_ ASL

\_\_\_ Total Communication

\_\_\_ Cued Speech

Setting:

\_\_\_ Mainstream

\_\_\_ Special Education

\_\_\_ DHH