Pediatric Case History

Please complete this form and bring it with you to your child's appointment. If you have any questions or concerns about your child's hearing test, please contact **LeMay Hearing & Balance at www.LeMayAudiology.com.**

Child's Name ______________________ Date of Birth ________________ Age ____________

Father's Name ________________________ Mother's Name ___________________________

Child's Pediatrician _______________________ Child's Doctor ___________________________

Who referred you to LeMay Hearing & Balance? ________________________________

Why was your child referred for a hearing test? ________________________________

Has your child's hearing been tested before? ☐ Yes ☐ No

If yes, when and where was your child tested? ________________________________

If yes, what were you told about the results of that test? ________________________

Has your child been tested for speech, motor skills, or other concerns? ☐ Yes ☐ No

If yes, what were you told about the results of those tests? ______________________

Does your child have a history of ear infections? ☐ Yes ☐ No

If yes, how frequently has (s)he had an ear infection? ___________________________

If yes, when did the last ear infection occur? ________________________________

What type(s) of treatment has your child been given for his/her infection(s)? ______________

Is there a history of hearing loss in your family? ☐ Yes ☐ No

If yes, who had a hearing loss and at what age was their hearing loss identified? __________

Did any problems occur during the pregnancy or delivery of this child? ☐ Yes ☐ No

If yes, please describe. ________________________________

Does your child receive any special services (such as speech therapy)? ☐ Yes ☐ No

If yes, please list all. ________________________________

Please provide us with any additional background information that you believe would be helpful to us as we evaluate your child's hearing.