THE Hearing & Dizziness CLINIC

Case history – Child

Child's Name: _____

Date of Birth: _____

School: _____

Grade in School: _____

Email: _____

What brings you here today? _____

_____

Did your child receive a hearing screening at birth? What were the results?

☐ Pass ☐ Fail ☐ I don't remember

Do you have any concerns about your child's hearing? _____

_____

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

If yes, how were they treated?

When was their last ear infection? _____

Has your child ever seen an Ear Nose and Throat doctor for their ears? ☐ Yes ☐ No

If yes, please explain when, why and what the doctor recommended: _____

_____

Does your family have a history of hearing loss? ☐ Yes ☐ No

If yes, list relation and at what age did they experience the hearing loss. _____

_____

_____

Does your child have any of the following?

☐ Frequent runny nose ☐ Frequent colds or sinus infection ☐ Ringing/ buzzing ears

☐ sore throat/tonsil issues ☐ allergies ☐ dizziness

Has your child had any previous ear surgery? ☐ Yes ☐ No

If yes, please list the procedures performed: _____

_____

Has your child had their hearing tested by an Audiologist? ☐ Yes ☐ No

If yes when and what was the result? _____

_____

Does your child currently wear a hearing aid or use an FM system in class? ☐ Yes ☐ No

Has your child seen a speech language pathologist in the past? ☐ Yes ☐ No

Are you concerned about your child's speech and language development? ☐ Yes ☐ No

Are you concerned about your child's behaviour at home, school or daycare? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

_____

Were there complications before during or after your child's birth? ☐ Yes ☐ No

If yes, please explain _____

_____

Were there delays in your child's development? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

Has your child had any serious illness or accidents? ☐ Yes ☐ No

If yes, please explain _____

_____

Does your child take any medications? ☐ Yes ☐ No

If yes, what? _____

_____

_____

Please indicate your child's history if applicable:

☐ Admitted to Neonatal Intensive Care Unit

☐ Exposure to Ototoxic Medication

☐ Bacterial Meningitis

☐ ECMO

☐ Premature (>36 weeks gestation)

☐ Craniofacial & Auditory Abnormalities

☐ Head Trauma

☐ Hyperbilirubinemia

☐ Low Birth Weight (Less than 1500g)