Youth Case History (age 5-16)

Name:_____ Date:_____
Referring Physician:_____Date of Birth_____

Briefly describe the reason for today's visit?_____

Has your child ever had a hearing test? Yes No

Do you have any concerns about your child's hearing? Yes No

Does your child seem to hear better on some days than others? Yes No

Does anyone in the family (sisters brothers, aunts, grandparents)
have a problem with language, learning, hearing, or speech? Yes No

Were there any complications during pregnancy or delivery? Yes No

Were any of the following present after your child's birth or during the first two months? (circle all that apply)

Stayed in hospital after mother	Prematurity
Birth weight less than 5 lbs.	Poor weight gain
Did not respond to sounds or people	Appeared yellow
Was in an incubator or isolette	Infections at birth
Difficulty breathing	Physical deformities
High fever	Failed infant hearing screen

How is your child's general health? Good Average Poor

Is your child taking any medication now? Yes _____ No

Has your child ever been hospitalized? Yes _____ No

Has your child experienced ear infections or other ear disorders? Yes No

Has your child had any ear surgery? Yes_____ No

What illnesses has your child had? (circle all that apply)

High fever	Dizziness	Convulsions	Pneumonia	Rheumatic Fever
Head injury	Ear injury	Allergies	Asthma	Heart problems
Encephalitis	Meningitis	Tonsillitis	Measles	Other_____

What questions would you like to have answered as a result of today's testing?

_____
_____
_____