MEDICAL HEARING ASSOCIATES, LTD.

PEDIATRIC CASE HISTORY

Child's Name: _____ D.O.B.: _____ Grade: _____

Referring Physician: _____ Mother's Name: _____

Concern: _____ Father's Name: _____

Otological History:

1. Has your child experienced any ear infections? Yes / No

If yes,s how frequently? _____

When was the most recent infection? _____ Treatment?_____

2. Has your child ever been seen by an ENT (ear, nose & throat) physician? Yes / No

If yes, physician name: _____ When: _____

Concern at the time: _____

3. Has your child ever had ear surgery? Yes / No

If yes, describe: _____

4. Has your child ever had a diagnostic hearing test in the past? Yes / No

If yes, when? _____ Results? _____

5. Did your child pass a hearing screening in the hospital when born? Yes / No

Please check (√) if your child has experienced any of the following:

○ Hears noises in the ears ○ Drainage from the ear ○ Balance difficulties

○ Often asks for repetition ○ Ear pain ○ Wax accumulation

○ Swimmers ear ○ Failed hearing screening ○ Speaks loudly

○ Sensitive to loud noises ○ Difficulty with directions ○ Hyperactivity

○ Short attention span ○ Difficulty following stories ○ Academic difficulty

○ Diagnosed ADD/ADHD ○ "Hears but does not listen" ○ Known behavioral problems