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### Pediatric Case History

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referred by? \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Speech | language delay

Failed hearing screening

Newborn hearing screening

Other (please explain) \_\_\_\_\_

Has your child had a hearing test before? Yes No

Is there a history of childhood hearing loss in the family? Yes No

Has your child ever had ear infections? Yes No  
 If so, how many and date of most recent infection \_\_\_\_\_

Has your child ever had ear surgery? Yes No  
 If so, please explain \_\_\_\_\_

Please list any current medications your child is taking \_\_\_\_\_

Please check all that apply

- Premature birth
- Low birth weight (under 5 lbs)
- Pediatric intensive care at birth
- Chronic illness (please explain) \_\_\_\_\_
- Oxygen required at birth
- Failed newborn hearing test
- Developmental delay

Any additional comment of information that you would like us to know:

Signature \_\_\_\_\_ Date \_\_\_\_\_