ELITE HEARING & BALANCE

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PEDIATRIC CASE HISTORY

PATIENT INFORMATION

Legal name: _____ Preferred name: _____

Date of birth: _____ Today's date: _____

Person completing this form: _____ Relationship to child: _____

Referring provider: _____ Primary care provider: _____

REASON FOR TODAY'S VISIT

- ☐ Hearing concern
- ☐ Speech/language concern
- ☐ Failed newborn screening
- ☐ Routine hearing check
- ☐ Failed school/pediatrician screening
- ☐ Frequent ear infections
- ☐ Dizziness or balance concerns
- ☐ Follow-up evaluation

PRENATAL AND BIRTH HISTORY

Born: ☐ Full term ☐ Premature (gestational age: _____ weeks)

Birth weight: _____

NICU stay: ☐ Yes ☐ No If yes, length of stay and reason: _____

Oxygen or breathing support after birth ☐ Yes ☐ No

Jaundice requiring treatment ☐ Yes ☐ No

Maternal illness or infection during pregnancy ☐ Yes ☐ No

If yes, please describe (e.g., CMV, rubella, gestational diabetes) : _____

Complications during pregnancy or delivery: _____

MEDICAL HISTORY

Please select all that apply:

- ☐ Meningitis/ encephalitis
- ☐ Congenital cytomegalovirus (CMV)
- ☐ Craniofacial anomalies
- ☐ Genetic syndrome
- ☐ Autism spectrum disorder
- ☐ Seizures / convulsions
- ☐ Head trauma/injury
- ☐ Chemotherapy or ototoxic medication exposure
- ☐ Allergies/sinus problems
- ☐ ADD/ADHD

Major diagnosis, surgeries, hospitalization, or other relevant medical history: _____

_____

Current medications: _____

HEARING HISTORY

Newborn hearing screening ☐ Passed ☐ Did not pass

Family history of hearing loss ☐ Yes ☐ No if yes, specify: _____

History of middle ear infection ☐ Yes ☐ No

If yes, frequency: ☐ Once per year ☐ 2-3 per year ☐ 4 or more per year

History of PE tubes ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Approximate age your child reached each milestone

Sat unsupported:_____ Walked independently:_____ First word:_____

Used a two-word sentence _____

Current communication: ☐ Gestures/vocalizations ☐ Single words ☐ Short phrases ☐ Full sentences

Speech be understood by others: ☐ Yes ☐ No

Current services: ☐ None ☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy

Educational plan: ☐ None ☐ IEP ☐ IFSP ☐ 504 Plan

LISTENING AND COMMUNICATION BEHAVIOR CHECKLIST

Behavior	Yes	No	Sometimes
Responds to name when called	☐	☐	☐
Startles or reacts to sudden loud sounds	☐	☐	☐
Turns toward the source of a sound	☐	☐	☐
Turns the TV or device volume up louder than others prefer	☐	☐	☐
Asks “what?” or requests repetition	☐	☐	☐
Appears to ignore others when spoken to	☐	☐	☐
Understands simple directions without visual cues	☐	☐	☐
Uses age-appropriate words or sentences	☐	☐	☐
Has difficulty hearing in noisy environments (e.g., classroom)	☐	☐	☐

ADDITIONAL COMMENTS OR CONCERNS

Please share anything else you would like us to know before your child’s evaluation:

_____

_____

CONSENT FOR EVALUATION

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize Elite Hearing & Balance to evaluate my child's hearing and/or balance and to contact me with the results and any recommended follow-up care.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____