Hearing Clinic at SUNY Geneseo
Sturges 212
One College Circle
Geneseo, New York 14454
585-245-5332

PEDIATRIC CASE HISTORY FORM for AUDIOLOGY

Child's Name:_____ Date of Birth:_____ Gender: ☐ M ☐ F

Address:_____
(Street/Route) (City/State) (Zip)

Parent(s)/Guardian: _____

Address (if different from above): _____

Who referred you to the Speech and Hearing Clinic? _____

I. GENERAL MEDICAL INFORMATION

What concerns prompted you to schedule the hearing evaluation for your child? _____

_____

What is the name and address of your child's pediatrician? _____

_____

Were there any complications during pregnancy (illnesses, medications, accidents)? _____

_____

How many ear infections has your child had? _____ Date of most recent infection _____

Has you child previously had or does he/she currently have PE tubes? Yes No

Has your child had an ear injury or ear surgery? Yes No

If yes, which ear(s)? ☐ Left Ear ☐ Right Ear ☐ Both Ears

Does your child have any current health problems? Yes No

If yes, please describe. _____

Is your child currently taking any medication(s)? Yes No

If yes, please list. _____

II. HEARING LOSS AND DEVELOPMENTAL INFORMATION

Were there any delays in your child reaching his/her developmental milestones (sitting, walking, babbling, first word)? Yes No

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

If yes, what are they? _____

Has your child previously had his/her hearing tested? Yes No

If yes, where? _____ Results_____

Is there a family history of hearing loss? Yes No

If so, please describe. _____

Do you have any concerns regarding your child's speech and language development? Yes No

If yes, please describe. _____

Is your child currently receiving speech-language therapy? Yes No

If yes, where? _____

Does your child have any known behavioral or learning problems? Yes No

If yes, please describe._____

III. EDUCATIONAL INFORMATION

What is the name of the school your child attends? _____

What is your child's current grade level in school? _____

What is the name of your child's teacher(s) _____

Are there any concerns at school (reading, attention, behavior)? Yes No

If yes, please describe._____

Is your child currently receiving any support services through his/her school district? Yes No

If yes, for which areas? _____

Date completed: _____