Child Case History

Name: _____ Date: _____

Age: _____

For what reason was this hearing test arranged?

_____

_____

_____

Has your child ever had a hearing test before? If so, when and where?	❑ 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 your family have problems with hearing?	❑ Yes ❑ No

Were any of the following present after your child's birth or during the first two months?

❑ Prematurity	❑ Appeared yellow
❑ Poor weight gain	❑ Stayed in hospital after mother went home
❑ Was in an incubator	❑ Infections at birth
❑ Did not pass hearing screening at birth	❑ Physical deformities
❑ Difficulty breathing	❑ High fever
❑ Birth weight less than 5 pounds	
Does your child turn toward sound?	❑ Yes ❑ No
Has your child had ear infections?	❑ Yes ❑ No How many? _____
Has your child had tubes placed in the ear(s)?	❑ Yes ❑ No If so, which ear? _____