

SHOW LOW

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Victoria Karim
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Pediatric Case History

Name: _____ Age: _____ Birth Date: _____

Referred By: _____ Today's Date: _____

PRIMARY COMPLAINT: _____

Do you think your child has a hearing problem? Yes No

Has your child ever had a hearing test before? Yes No If yes, describe the results: _____

Did your child pass a newborn hearing screening? Yes No

Does your child have ear infections? Yes No (If yes, please answer questions on reverse)

Has your child ever had ear surgery? Yes No Describe: _____

Do you believe your child's speech and language is developing normally? Yes No

Do you believe your child's physical ability is developing normally? Yes No

Does your child require special services, such as speech therapy or remedial help? Yes No

Was the pregnancy normal? Yes No If yes, describe complications: _____

Was the delivery of your child normal? Yes No If yes, describe complications: _____

Has your child had any illnesses or medical conditions? Yes No If yes, describe: _____

Is your child taking any medications? Yes No If yes, please list: _____

Does anyone in your family have a hearing problem? Yes No

Is there any additional information that you believe might be helpful?

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Otitis Media: Patient/Parent Questionnaire

Ear infections or middle ear fluid can result in hearing problems. If your child has had recurrent ear infections or persistent middle ear fluid, your answers to the following questions will help us to determine the necessary treatment for your child.

At what age did the ear infection or middle ear fluid first occur? _____

How many ear infections have occurred in the last six months? _____ In the last twelve months? _____

How long has the current middle ear infection or fluid been present? _____

Has treatment included the use of antibiotics? Yes No

If you can, please list the medicines used and the duration of use:

Medicine: _____	Duration of use: _____
_____	_____
_____	_____
_____	_____

Has antibiotic prophylaxis (once a day dosage for an extended period) been tried? Yes No Medicine: _____

Has your child had ear tubes inserted? Yes No If yes, how many times? _____

Has your child had a tonsillectomy or adenoidectomy? Yes No

Any siblings at home? Yes No If yes, how many? _____

Is your child in day care? Yes No

Does anyone smoke at home? Yes No

Does your child: Snore or have difficulty breathing at night? Yes No

Have recurrent sinusitis or colored nasal drainage? Yes No

Have recurrent tonsillitis or sore throats? Yes No

Have clumsiness, balance, or coordination problems? Yes No

Have difficulty breathing through their nose? Yes No

Have nasal allergies or food allergies? Yes No