SHOW LOW
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PEDIATRIC CASE HISTORY

Name: ______________________ Age: ________ Birthdate: ______________

Referred By: ______________________

Primary Care Physician: ______________ 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

Describe the results: ______________________________

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

Did your child pass a newborn hearing screening? ☐ Yes ☐ No

Has your child ever had an ear surgery? ☐ Yes ☐ No

If yes, please describe: ______________________________

Do you believe you 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 of this child normal? ☐ Yes ☐ No

If not, describe complications: ______________________________

Was the delivery of this child normal? ☐ Yes ☐ No

If not, describe complications: ______________________________

Has your child had any illnesses or medical conditions ☐ Yes ☐ No

If so, describe: ______________________________

Is your child taking any medications? ☐ Yes ☐ No

Describe: ______________________________

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 QUESTIONAIRE

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 can 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 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

If yes, name of medicine: ____________

Has your child had tubes inserted? ☐ Yes ☐ No

If yes, how many times? ____________

Has your child had a tonsillectomy or adenoidectomy? ☐ Yes ☐ No

How many siblings are at home? ____________

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 the nose? ☐ Yes ☐ No
- Have nasal allergies or food allergies? ☐ Yes ☐ No