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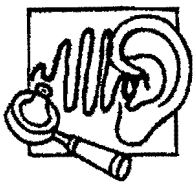

Preferred Audiology Services – Partners in Hearing Healthcare
121 Congressional Lane, Rockville, Maryland 20852
(301) 468-0551 (301) 943-3318 (301) 937-0488 fax

Pediatric Case History

Child's Name: _____ **Date of Birth** _____

Mother's Name: _____ **Father's Name:** _____

Pediatrician: _____

Why is your child having a hearing test? _____

When did you first notice there might be a problem? _____

Has anyone else in the family ever had a hearing problem during childhood? _____

Were there any significant problems or concerns during the pregnancy and/or delivery? _____

Has your child had any serious illness? _____

Has your child had any serious injuries? _____

Has your child had reoccurring ear infections? _____ Approximately how many per year? _____

Has your child had PE tubes? _____ Which ear? _____ When? _____

Did your child pass the Newborn Infant Hearing Screening? _____ If no, please explain: _____

Did you child reach all major developmental milestone on time? _____ If no, please check the delayed developmental milestone.

_____ Turning over _____ Sitting unsupported _____ Walking

_____ Speech & Language Development

Does your child speak clearly? _____ If no, please explain _____

_____ _____

Parent's signature Date

Submit Print