# Youth Case History (age 5-16)

Name:_____ Date:_____
Referring Physician:_____Date of Birth_____

Briefly describe the reason for today's visit?_____

Has your child ever had a hearing test? 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 the family (sisters brothers, aunts, grandparents)
have a problem with language, learning, hearing, or speech? Yes No

Were there any complications during pregnancy or delivery? Yes No

Were any of the following present after your child's birth or during the first two months? (circle all that apply)

| | |
|---|---|
| Stayed in hospital after mother | Prematurity |
| Birth weight less than 5 lbs. | Poor weight gain |
| Did not respond to sounds or people | Appeared yellow |
| Was in an incubator or isolette | Infections at birth |
| Difficulty breathing | Physical deformities |
| High fever | Failed infant hearing screen |

How is your child's general health? Good Average Poor

Is your child taking any medication now? Yes _____ No

Has your child ever been hospitalized? Yes _____ No

Has your child experienced ear infections or other ear disorders? Yes No

Has your child had any ear surgery? Yes_____ No

What illnesses has your child had? (circle all that apply)

| | | | | |
|---|---|---|---|---|
| High fever | Dizziness | Convulsions | Pneumonia | Rheumatic Fever |
| Head injury | Ear injury | Allergies | Asthma | Heart problems |
| Encephalitis | Meningitis | Tonsillitis | Measles | Other_____ |

What questions would you like to have answered as a result of today's testing?

_____
_____
_____