



**Case History Questionnaire  
Pediatric Audiologic Evaluation**

**Identifying Information:**

Child's name	Birth date	Age
Sex	Grade	Referral source
Person completing form: Name	Person completing form: Relationship	Date

- Has the child seen a doctor in the past 6 months?  
whom? \_\_\_\_\_ Yes No
- Has the child seen a doctor specializing in the ear?  
when/where? \_\_\_\_\_ Yes No
- Has the child ever had a hearing test?  
when/where? \_\_\_\_\_ Yes No
- Has the child had any type of ear surgery?  
type/date? \_\_\_\_\_ Yes No
- Does the child take medicine daily?  
for what condition? \_\_\_\_\_ Yes No
- Are there other medical conditions present?  
please list \_\_\_\_\_ Yes No

**Does the child have any of the following symptoms?**

- |                              |     |    |
|------------------------------|-----|----|
| Deformity of the ears        | Yes | No |
| Drainage from the ears       | Yes | No |
| Sudden or rapid hearing loss | Yes | No |
| Acute or chronic dizziness   | Yes | No |
| Ringing in the ears          | Yes | No |
| Pain in the ears             | Yes | No |
| Earwax accumulation          | Yes | No |

Do you have concerns about how the child hears? Yes No  
Please describe: \_\_\_\_\_

**Does the child:**

- |  |     |    |
|--|-----|----|
| Respond if you call him/her from another room? | Yes | No |
| Respond to his/her own name?                   | Yes | No |
| Try to look toward the sound source of noise?  | Yes | No |
| Alert to familiar sounds?                      | Yes | No |
| Attend to unfamiliar sounds?                   | Yes | No |

Please describe any 'no' responses: \_\_\_\_\_  
\_\_\_\_\_



**Does the child respond to:**

Loud noises?	Yes	No	Speech when facing the speaker?	Yes	No
Doorbell or telephone?	Yes	No	Speech over the phone?	Yes	No
Whispered speech?	Yes	No	Speech from another room?	Yes	No
Faint sounds?	Yes	No			

Do you have concerns about how the child talks?	Yes	No
Is the child having any problems learning at school?	Yes	No
Are there any problems with the child's development?	Yes	No
Did the child fail their newborn hearing screening?	Yes	No
Has the child had any high fevers?	Yes	No
Has the child had any seizures?	Yes	No
Has the child had any head or ear injuries?	Yes	No
Does the child experience allergies?	Yes	No
Does the child experience any sinus/congestion?	Yes	No

Please describe any 'yes' responses: \_\_\_\_\_  
 \_\_\_\_\_

**Speech Development:**

**Does the child display:**

Delay in early speech development?	Yes	No
Small vocabulary compared to peers?	Yes	No
Problem speaking clearly?	Yes	No
Problem understanding others?	Yes	No
Speech therapy now or in past?	Yes	No

Please describe any 'yes' responses: \_\_\_\_\_  
 \_\_\_\_\_

**Pregnancy and Birth History:** Please describe/list complications if any: \_\_\_\_\_  
 \_\_\_\_\_

**Is there a Family History of:**

Neurologic diseases	Yes	No	Learning problems	Yes	No
Speech problems	Yes	No	Hereditary illness	Yes	No
Hearing loss	Yes	No	Other Disorders	Yes	No

Please describe any 'yes' responses: \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_