CASE HISTORY

(CHILD)

NAME: _____ DATE:_____
DATE OF BIRTH: _____ REFERRED BY: _____

Reason for the visit: (circle) decreased hearing ringing in ears

Hearing better in: RIGHT LEFT How long has hearing been decreased?_____

Ringing in ears: RIGHT LEFT BOTH NEITHER

Pressure or fullness in ears: RIGHT LEFT NEITHER

Has hearing ever been tested? YES NO If yes, when and where?_____

Has child had any: (circle) all that apply:

ear infection *ear surgery* *history of noise exposure* *family hx of hearing loss* *dizziness*

PREGNANCY INFORMATION:

Was the birth on time: YES NO If no, explain
_____

Any problems noted at birth:
_____

Was the mother exposed to any of the following during pregnancy:

german measles *mumps* *meningitis* *infections*

How old was the child when he/she:

sat alone_____ walked _____ said first word _____

said two word sentences _____

MEDICAL HISTORY:

Has child ever had:

measles *mumps* *meningitis* *cmv* *major illness or infections*

comments:
_____
_____