Resurrection Health Care®
For All of You, All of Your Life

Resurrection Medical Center
www.reshealth.org

Pediatric Case History Form

Audiology Department
773-792-5258
773-990-7788 (fax)

Patient's Name: Date of Evaluation:
Date of Birth: If applicable EI #:
Physician: If applicable EI Case Manager:

Please circle all numbers that apply to your child.

Reason for Referral:

1. Rule out a hearing loss as a cause for the patient's possible problems/delays.
2. Patient doesn't seem to be hearing well all the time.
3. Patient seems to hear well sometimes but not others.
4. The patient seems to hear but not understand.
5. Patient has lots of ear problems like middle ear fluid or infections.
6. Patient has a disease that may cause hearing loss.
7. Other: _____

Parental Concerns:

1. The parent has no concerns about hearing.
2. The parent has concerns about hearing.
4. The parent is concerned that the child does not speak.
5. The parent is concerned that the child is not producing enough speech expected for his/her age.
6. The parent is concerned that the child's speech is difficult to understand.
7. The parent is concerned that the child has poor balance or walking abilities.
8. The parent is concerned that the child's medical problems with the ears are affecting hearing.
9. Other: _____

Birth and Medical History:

1. The prenatal history was normal.
2. The prenatal history was not normal.
   Please provide information: _____
   _____
3. The prenatal history is unknown. The patient was adopted at ___ age from _____.
4. The patient was premature.
5. The patient is a twin/triplet.
6. There were no problems at delivery.
7. There were problems at delivery. They included _____
   _____.

8. The patient had no troubles for the first month after birth.
9. The patient had troubles for the first month after birth.
10. The patient's Universal Newborn Hearing Screening was normal at birth.
11. The patient's Universal Newborn Hearing Screening was not normal at birth.
12. The patient's results are not known by the family. The patient was born at _____ hospital or location.

13. The patient has been diagnosed with an expressive/receptive speech delay.
14. The patient has been diagnosed with autism/pervasive developmental disorder (PDD).
15. The patient's problems have not yet been diagnosed.
16. The patient has been diagnosed with Down Syndrome.
17. The patient began ear infections before his/her first year of life.
18. The patient has had _____ number of ear infections.
19. The most recent ear infection was diagnosed in the past three months.
20. The patient does not make eye contact with others.
21. The patient's vision is normal.
22. The patient's vision is not normal.
23. Allergies are a concern. They include _____ (i.e. food or environmental)
24. Sinus problems are a concern.
25. Snoring is present often.
26. There are smokers present around the patient.
27. There are pets, including fish bowls/tanks, present around the patient.
28. The patient is in daycare/preschool/grade school.
29. The patient has _____ siblings.
30. The patient's caregiver speaks a different language.
31. Languages spoken at home are _____.
32. There is a family history of childhood hearing loss on either side of the family.
33. There is a family history of childhood speech and language problems.
34. There is a family history of ear wax accumulation, middle ear fluid, or infections.
35. The patient has a cranial facial anomaly.
36. The patient has had his/her initial Child & Family Connections evaluation. Dates: _____
37. The patient is receiving the following therapies: Circle all that apply: Occupational Therapy/Physical Therapy/ Developmental Therapy/ Aural Rehabilitation/ Speech and Language Therapy
38. The patient was recommended for the following therapies:_____ but has not yet begun services.
39. The patient is in a regular play group and/or parent/tot group.
40. Please provide details of any specific concerns: _____
_____

Person Completing Form: _____ Relationship: _____
Patient's Name:_____