CENTRAL ILLINOIS HEAIRNG, LTD.

PEDIATRIC CASE HISTORY

Name _____ **Age**: _____ **Birthdate**: _____

Referred by: _____ ****** PLEASE USE BLACK INK *****

- Primary complaint: _____
- Do you think your child has a hearing problem? Yes _____ No _____
- Has your child ever had a hearing test before? Yes _____ No _____
  Describe the results _____
- Does your child have ear infections? Yes _____ No _____
- Has your child ever had ear surgery? Yes _____ No _____ Describe _____
- Do you believe your child's speech and language is developing normally? Yes ____ No ____
- Do you believe your child's physical ability is developing normally? Yes _____ No _____
- Does your child require special services, such as speech therapy or remedial help?Yes__ No__
- Was the pregnancy normal? Yes _____ No _____
  Describe complications

_____

- Was the delivery of this child normal? Yes _____ No _____
  Describe complications

_____

- Has your child had any illnesses or medical conditions? Yes _____ No _____
  Describe

_____

- Is your child taking medication? Yes ____ No _____ Describe
  _____
- Does anyone in your family have a hearing problem? Yes _____ No _____
- Is there any additional information that you believe might be helpful?
  _____
  _____

Authorization is hereby granted to this institution to release test findings. Please provide names and addresses of persons or agencies to which you would like this report sent:

1. _____ 2. _____ 3. _____

Signature: _____ Date: _____ (Rev. 8/30/16)