Blue Ridge Speech & Hearing Center

19465 Deerfield Avenue, Suite 201
Lansdowne, VA 20176
703-858-7620 703-858-7657 FAX
www.speechhearing.org

Pediatric Case History Form (Audiology)

Name: ____________ **Date:** ____________
Address: ____________ **Sex:** ____________
____________ **Age:** ____________
Date of Birth ____________
Referred By: ____________ **Pediatrician:** ____________
Home Phone: ____________ **Cell Phone:** ____________
Email Address: ____________

Ethnicity: ____ African American ____ Asian ____ Caucasian
____ Hispanic / Latino ____ Other: ____________

Father's Name: ____________ Mother's Name: ____________
Father's Address: ____________ Mother's Address: ____________
____________ ____________
Fathers' Employer: ____________ Mother's Employer: ____________
Father's Position: ____________ Mother's Position: ____________
Work Phone: ____________ Work Phone: ____________
E-Mail Address: ____________ E-Mail Address: ____________

Parental Marital Status: ____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

Combined Income (Please check one)

____ $12,000-$20,000 ____ $40,000-$60,000 ____ $80,000-$100,000 ____ Over $120,000
____ $20,000-$40,000 ____ $60,000-$80,000 ____ $100,000-$120,000

How did you hear about us? (Please check all that apply)

____ Word of mouth ____ Phone book / Yellow Pages ____ School system
____ Internet ____ Physician ____ Other: ____________

____ If you **do not** want to receive information about new services, fundraising events or other Blue Ridge Speech and Hearing news, please check here.

Statement of Problem

1. Reason for referral: ____________
2. When was the problem first noted: ____________
3. Has the child been seen elsewhere in regards to the problem? ____ Yes ____ No
   If so, when and what was suggested? ____________
4. What do you think caused the problem? ____________
5. What difficulties has he / she experienced related to his / her hearing? ____________
6. If you think he / she has a hearing loss, list the sounds that he / she seems to hear consistently: ____________

7. Has he / she ever worn a hearing aid? _______ Yes ________ No
If yes, at what age were they fit with hearing aids? ______________________________
Make & Model: ______________________________

Medical History

8. Was he / she premature? _______ Yes ________ No
How many weeks premature? ______________________________
9. How much did he / she weigh? ______________________________
10. What was his / her APGAR? ______________________________
11. Is he / she currently taking medication of any kind? _______ Yes ________ No

Please list medications:

Medication	Dosage	Reason For Taking

12. Does he/she have:

Disorder	Never	Rarely	Frequently	Date of Last Episode
Ear Aches				
Ear Infections				
How was it treated?				
Draining Ears				
Allergies				
Sinusitis				
Frequent Colds				
Does it affect their hearing?				
Fungal Infections (ears)				
Excessive Ear Wax				
Dizziness / Vertigo / Imbalance				
Tinnitus / Ringing in ears/ Roaring in ears				
Facial Numbness				
Blurred Vision				
Convulsions				
Blackouts				
Heart Problems				
Strokes				
Illnesses with High Fevers				

13. If he / she has had any of the previously listed disorders in the past year, please describe the nature of the illness, the treatment, and state whether it affected his/her hearing:

____

14. Has he / she ever had ear surgery? ___________ Yes ___________ No
If yes, when and what: ______________________________

History of Pregnancy and Birth

15. List any illness that you had during your pregnancy:
16. Were any medications taken during pregnancy? ____ Yes ____ No
    If yes, why were they taken?
17. Where there any abnormalities of the child noted at birth? ____ Yes ____ No
    Describe: ____________________
18. **Did the child pass his / her newborn hearing screening?** ____ **Yes** ____ **No**
19. What hospital were they born at? ____________________

Developmental History

20. Was he / she slow in:

Sitting unsupported	____ Yes	____ No	Acquired: ________
Creeping / Crawling	____ Yes	____ No	Acquired: ________
Walking	____ Yes	____ No	Acquired: ________
Self-feeding	____ Yes	____ No	Acquired: ________
Toilet training	____ Yes	____ No	Acquired: ________

    For what reason was he/she slow? ____________________
21. Was there any problem with balance? ____ Yes ____ No

Speech History

22. When did the child babble normally? ____________________
23. Did he / she, at any time, stop babbling? ____ Yes ____ No
24. When did he / she begin to talk? ____________________
25. Is his / her speech intelligible to people outside the family? ____ Yes ____ No
26. Does he / she have any speech problems? ____ Yes ____ No
    If yes, please describe: ____________________

Family History

27. Is there any history of hearing loss or deafness in the family? ____ Yes ____ No
28. If yes, please describe: ____________________
29. How many children are in the family? ____________________
30. Do any of your other children have speech or hearing problems? ____ Yes ____ No
    If yes, please describe: ____________________

Educational History

31. What grade are they in school? ____________________
32. Is he / she in a special class? ____ Yes ____ No
    Specify: ____________________
33. Does he / she receive any special services in school? ____ Yes ____ No
    Specify: ____________________
34. Do you mind if we discuss your child's special services in front of your child? ____ Yes ____ No
35. Do any subjects cause particular difficulty? ____ Yes ____ No
    Specify: ____________________
36. Does he / she like school? ____ Yes ____ No
37. Is his / her work satisfactory? ____ Yes ____ No
38. Additional comments: ____________________

Statement of Release

I, ______________________________

Your name here

hereby request and/or grant permission to the above named Clinic to send a report of the diagnostic findings, evaluation, and therapy progress of this case to the following:

Pediatrician: ____________________

Address: ____________________

____

Phone: ____________________

FAX: ____________________

ENT: ____________________

Address: ____________________

____

Phone: ____________________

FAX: ____________________

Audiologist: ____________________

Address: ____________________

____

Phone: ____________________

FAX: ____________________

Neurologist: ____________________

Address: ____________________

____

Phone: ____________________

FAX: ____________________

School: Loudoun County Public Schools

____

Address: ____________________

____

Phone: ____________________

Fax: ____________________

Patient: ____________________

Address: ____________________

____

Phone: ____________________

FAX: ____________________

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Patient Name: ______________________________
First Middle Last

Permanent Address: ______________________________
(no PO BOX): Street City State Zip

Mailing Address: ______________________________
(if different from above)
Street City State Zip

Home Phone: __________ Work Phone: __________ Cell: __________
Date of Birth: __________ Sex: ____ Male ____ Female
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Patient Employment Information (if patient is a minor, parent complete):

Employee / Father
Place of Employment ______________________________
Name City, State Occupation Telephone

Employee / Mother
Place of Employment ______________________________
Name City, State Occupation Telephone

Who referred you to this office? ______________________________
Nearest Relative: ______________________________
(not at same address) Name Telephone

_____ Private Pay _____ Insurance

Primary
Insurance Name: ______________________________

____
Address City State Zip

Subscriber's Name: __________ ID #: __________
Group Name: __________ Group #: __________

Secondary
Insurance Name: ______________________________
Address City State Zip

Subscriber's Name: __________ ID #: __________
Group Name: __________ Group #: __________

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process these claims. I also authorize payment of medical benefits to the provider for services described.

______________________________ __________
Signed Date

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