# Ball State University
# Audiology Clinic
## Child Case History

Name _____ Birth Date _____ Age _____ Gender ❑ M ❑ F

Audiologist _____ Grad. Clinician _____ Date _____

Referral Source _____ Child's PCP _____

School _____ Grade _____ Teacher _____

1. **Reason for Visit / Parental Concern:** _____

_____

2. **Previous Hearing Evaluation:** ❑ Yes ❑ No

When / Where: _____

Results: _____

Recommendations made: _____

3. **History of Ear Infections:** ❑ Yes ❑ No ❑ RT ❑ LT ❑ Both

Last occurrence: _____ First occurrence: _____

Frequency: _____

Treatment: ❑ Antibiotics ❑ PE Tubes (# of sets: _____) ❑ Other: _____

4. **Hearing Aids:** ❑ Yes ❑ No

Ear fit: ❑ RT ❑ LT ❑ AU Make / Model: _____

Age when first fit: _____ Hours used per day: _____

5. **Prenatal, Birth, and Developmental History**

a. Risk Factors ❑ Check if no risk factors

- ❑ Family History of Permanent Childhood Hearing Loss
- ❑ Mechanical Ventilation
- ❑ Craniofacial Anomalies
- ❑ Cytomegalovirus (CMV)
- ❑ Bacterial Meningitis
- ❑ In utero Infection
- ❑ Rubella
- ❑ Special Care / NICU (over 5 days)
- ❑ Herpes
- ❑ Hyperbilirubinemia requiring exchange or transfusion
- ❑ Toxoplasmosis
- ❑ Ototoxic Medications
- ❑ Genetic Syndromes Associated with Hearing Loss
- ❑ Syphilis
- ❑ Extracorporeal Membrane Oxygenation (ECMO)
- ❑ Other

Comments / Additional Information: _____

_____

b. Complications During Pregnancy ❑ None

Describe: _____

_____

c. Alcohol / drug use during pregnancy (prescription or non-prescription) ❑ Yes ❑ No

Describe: _____

_____

d. Normal delivery? ❑ Yes ❑ No

Issues: _____

_____

e. Complications immediately following birth or during first two weeks ❑ Yes ❑ No

Describe: _____

_____

f. Significant medical / health issues since birth ❑ Yes ❑ No

Describe: _____

6. **Speech / Language History**

a. Age of first word: _____ First word: _____

b. How does child make his/her needs known: _____

c. Is speech understood by others ❑ Yes ❑ No

7. **Developmental Milestones**

a. Developmental milestones met as expected ❑ Yes ❑ No

Comments: _____

b. Is child receiving therapy from other discipline (SLP, PT, OT, etc.) ❑ Yes ❑ No

Comments: _____

8. **Comments / Additional Information:**

_____

_____

_____

# Ball State University Speech and Audiology Clinic – Family Medical History Form

Patient: _____ Date: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (  ) _____ Other Phone: (  ) _____ Email: _____

Primary Care Physician: _____ City: _____

Maternal Ethnicity of Patient: Paternal Ethnicity of Patient: _____

Person Completing this Form *(if not patient):* _____ Relation to patient: _____

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Reason for Appointment: _____

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Please indicate if the patient or any relatives (including at least 3 generations) currently experience or have experienced the listed symptoms or conditions. Please provide additional information if possible and note which relative (e.g., maternal grandmother) when applicable. Information on family health can be useful in understanding potential causes for hearing, speech or language difficulties or other health issues. While some symptoms (e.g., miscarriages or fainting spells) may seem irrelevant, certain combinations of symptoms may signal an underlying condition that is related to the patient's primary concern.

**Otologic and Hearing problems:** **Relationship/Comments:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Hearing Loss Present at Birth, Childhood, or Young Adulthood | _____ |
| ☐ | ☐ | Hearing Loss, Any Age of Onset | _____ |
| ☐ | ☐ | Vertigo/Dizziness/Balance problems | _____ |
| ☐ | ☐ | Other | _____ |

**Vision Problems:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Premature and/or Progressive, Significant Vision Loss | _____ |
| ☐ | ☐ | Night Blindness | _____ |
| ☐ | ☐ | Tunnel Vision | _____ |

**Learning Disabilities/Developmental Delays:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Cognitive Function Impairment (Mental Retardation) | _____ |
| ☐ | ☐ | Speech/Language Delay | _____ |
| ☐ | ☐ | Motor Delay | _____ |
| ☐ | ☐ | Learning Disability of Unknown Cause | _____ |
| ☐ | ☐ | Autistic Spectrum Disorders | _____ |
| ☐ | ☐ | Other | _____ |

**Neurological or Cardiovascular Concerns:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Seizures | _____ |
| ☐ | ☐ | Fainting | _____ |
| ☐ | ☐ | Tremors | _____ |
| ☐ | ☐ | Heart Defect | _____ |
| ☐ | ☐ | Heart Attack | _____ |
| ☐ | ☐ | Irregular Heartbeat | _____ |



*LAS 12/10*

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Sudden Death (unexplained) | |
| ☐ | ☐ | SIDS | |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| ☐ | ☐ | Unusual Stature | |
| ☐ | ☐ | Craniofacial or Oral Abnormalities | |
| ☐ | ☐ | Cleft Palate/Lip | |
| ☐ | ☐ | Ear Anomalies | |
| ☐ | ☐ | Arthritis | |
| ☐ | ☐ | Frequent Broken Bones | |

**Kidney**

| | | | |
|---|---|---|---|
| ☐ | ☐ | Kidney Malformation | |
| ☐ | ☐ | Kidney Disease | |
| ☐ | ☐ | Blood in Urine | |

**Pigmentation**

| | | | |
|---|---|---|---|
| ☐ | ☐ | Heterochromia (eyes of different color or a multi-colored eye) | |
| ☐ | ☐ | Hair (early graying, white patches) | |
| ☐ | ☐ | Vitiligo | |
| ☐ | ☐ | Café au Lait Spots | |

**Reproductive/Pregnancy Concerns:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Stillbirth | |
| ☐ | ☐ | Miscarriage | |
| ☐ | ☐ | Early Menopause | |
| ☐ | ☐ | Consanguinity (interfamily relationship) | |
| ☐ | ☐ | Infertility | |

**Endocrine:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Diabetes | |
| ☐ | ☐ | Thyroid Disorder (enlarged thyroid - goiter) | |

**Genetic Disorders & Syndromes:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Stickler Syndrome | |
| ☐ | ☐ | Usher Syndrome | |
| ☐ | ☐ | Branchio-oto-renal Syndrome | |
| ☐ | ☐ | Pendred Syndrome | |
| ☐ | ☐ | Neurofibromatosis type II | |
| ☐ | ☐ | Mitochondrial Disorders | |
| ☐ | ☐ | Alport Syndrome | |
| ☐ | ☐ | Waardenburg Syndrome | |
| ☐ | ☐ | Long QT Syndrome/Jervell Lange-Nielsen | |

**Genetic Disorders & Syndromes *(continued)*:** **Relationship/Comments:**

| Patient | Relative | | |
|---|---|---|---|
| ☐ | ☐ | Pierre-Robin Sequence | |
| ☐ | ☐ | Treacher Collins Syndrome | |
| ☐ | ☐ | Connexin 26 Deafness | |
| ☐ | ☐ | Other Syndromes or Chromosomal Abnormalities | |

Has a family member ever had an evaluation by a geneticist? ☐ yes ☐ no

Please make any additional comments in the space provided below.



*LAS 12/10*

Medications and Supplements Form
Ball State Audiology Clinic

Name: _____ Date of Birth: _____ Phone Number:_____ Today's Date: _____

Please fill in all medications you take, whether regularly or as needed. Fill in as many categories as possible. If you already have a medication list that includes all of the information below, please feel free to bring that list to the appointment instead. Information on medications can be useful in understanding potential causes for hearing difficulties or other health issues. While some medications or supplements may seem irrelevant, certain combinations of medications and symptoms may relate to your hearing or balance problem(s).

| Name of Medications or Supplements | Dosage | How often you take the medication? | Reason for taking | Date Started |
|---|---|---|---|---|
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Please list allergies (medication or other): _____
_____
_____