COLUMBIA BASIN HEARING CENTER

Case History Questionnaire for Parents of Children with Hearing Loss

Please complete the following form pertaining to your child's hearing:

Child's name:_____

Parent/Guardian:_____ **Phone**:_____

I. **Chief Complaint**:_____

When problem first noted?_____

Extent of Problem_____

Previous examinations/evaluations_____

II. **Prenatal History**: Exposure to viral diseases during pregnancy? ☐ yes ☐ no

If yes, Which one:_____which month:_____

Drugs during pregnancy?_____

Trauma during pregnancy?_____

III. **Birth History**: Gestation at birth_____weeks Birth Weight _____lbs. _____ozs.

Bilirubin Level High? ☐ yes ☐ no Meningitis? ☐ yes ☐ no

IV. **Family History**: Childhood deafness in family? ☐ yes ☐ no Relationship to patient_____

Birth Defects or abnormalities? ☐ yes ☐ no Any other relatives?_____

V. **Developmental History**: First Smile _____age First Sat Up _____age

First Crawled _____age Started Walking_____age

VI. **Physical History**: Cleft Lip/Palate ☐ yes ☐ no Submucous Cleft ☐ yes ☐ no

Low-set ears ☐ yes ☐ no Poorly formed ears ☐ yes ☐ no

High fevers with illness ☐ yes ☐ no Ear infections ☐ yes ☐ no

How many?_____

Previous treatment for ear conditions_____

VII. What do you (parents) really think caused this hearing problem? _____

_____

Name of child's pediatrician:_____

Name of other physicians who have seen this child: _____