

CENTRAL ILLINOIS HEAIRNG, LTD.
PEDIATRIC CASE HISTORY

Name _____ Age: _____ Birthdate: _____

Referred by: _____

- 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)