Infant Case History (0-24 Months)

Infant Name ______________________________ Age ______ / ______
First Last MI Years Months

Parent / Guardian ______________________________ Date ______ / ______ / ______
First Last MI MM DD YYYY

Pediatrician ______________________________

Referring Physican ______________________________

Birthday History

Place of birth ______________________________ Birth Weight ______________

APGAR Score (if known) ____________________ Jaundiced? ☐ YES ☐ NO

Highest Bilirubin No. ____________________ Placed under lights? ☐ YES ☐ NO

Describe any pre /postnatal problems ______________________________

____

____

____

Concerns (check all that apply)

☐ Failed newborn hearing screening ☐ LEFT ☐ RIGHT ☐ BOTH

☐ History of hearing loss in the family? ☐ Inconsistent responses to sound

☐ Does not startle to loud sound ☐ Does not respond to their name

☐ Other ______________________________

____

____

Has your child's hearing been tested before? ☐ YES ☐ NO

Who ______________________________

When ______________________________

Where ______________________________

Results ______________________________

Do you think your child hears adequetly? ☐ YES ☐ NO

Has your child ever had:

☐ Ear Infections ☐ LEFT ☐ RIGHT ☐ BOTH

☐ Drainage from one or both ears ☐ Too much wax in the ears ☐ Ear tubes placed in the eardrums by an ENT Physician

Name ______________________________

When ______________________________

Where ____

Results ____

Is your child adopted? ☐ YES ☐ NO

Adopted from ____

Does your child know they are adopted? ☐ YES ☐ NO

Do you have a pre/postnatal report or history of their birth parents? ☐ YES ☐ NO

Has your child been evaluated by the Early Intervention Program? ☐ YES ☐ NO

Were they eligible for services? ☐ YES ☐ NO

Speech & Language

What concerns do you have about your child's speech? ____

____

____

Has your child been evaluated by any other medical specialist? ☐ YES ☐ NO

Check all that apply:

☐ Audiologist (elsewhere) ☐ Chiropractor ☐ Developmental Specialist

☐ Early Intervention Program ☐ Occupational specialist ☐ Pediatric neurologist ☐ Physical therapist

Medical History

Is there any medical diagnosis (i.e. Down Syndrome, Cerebral Palsy, etc.) ☐ YES ☐ NO

Specifics ____

____

____

List ALL illnesses and allergies (excluding slight colds) and dates ____

____

____

Has your child ever been hospitalized? ☐ YES ☐ NO

Specifics (circumstances, dates, results) ____

____

____

Family History

Is there a family history of hearing loss? ☐ YES ☐ NO

Who ____

What was the cause (if known)? ____

____

____

Medications

Please complete attached form

Mark H. Scoones, AuD, FAAA
Doctor of Audiology

Medication Documentation

Due to the new insurance guidelines for audiologist, it is mandatory that we document current medications prior to billing for your services.

Please complete this form and bring it with you to your appointment.

(Completion of this form is not necessary if you have a pre-printed list of your medications. Please give the list to the receptionist to copy.)

Please list each medication you are currently taking, including prescriptions, over-the-counter, herbals, vitamins/mineral/dietary supplements.

Medication Name	Dosage	Frequency	Route (oral, shots, dermal, etc.)

303 West First Street, Aberdeen, WA 98520 • T: 360.533.0633 F: 360.533.2541
Willapa Harbor Hospital • 800 Alder Street, South Bend, WA 98586 • T: 360.208.2373
www.westcoasthearing.com