UCA SPEECH-LANGUAGE HEARING CENTER
201 Donaghey Ave/UCA Box 4985 – Conway, Arkansas 72035-0001 – 501-450-3176

Child Case History (Hearing)

Person completing this form: _____

Relationship to the child: _____

I. IDENTIFICATION

Child's name: _____ Birth date: _____
Age: _____ Phone number: _____
Address: _____
_____
E-mail address:_____
Mother's name: _____
Father's name: _____
Referred by: _____
Address: _____
_____
Name of child's doctor: _____
Address: _____
_____

II. STATEMENT OF THE PROBLEM

A. Describe the problem: _____
_____
_____

B. When was the problem first noticed? _____
_____
_____

C. Has he/she had problems with ear infections in the past? If yes, how often has this occurred in the past year? _____
_____

D. Has he/she had P.E. tubes? If yes, when? _____
_____

E. Has he/she experienced any speech and/or language problems? If so, briefly describe. _____

_____

F. Has he/she had any learning problems? If so, briefly describe. _____

_____

III. HISTORY

A. Family History:

List any relatives of the child closer than second cousins who have or had a hearing loss. Indicate cause if known.

Name _____ Relation _____
Cause _____
Name _____ Relation _____
Cause _____
Name _____ Relation _____
Cause _____

B. Medical History:

Premature birth_____ Seizures_____
Measles _____ Mumps _____
Whooping cough _____ Ear infections _____
Scarlet fever _____ Allergies _____
High fever _____ Influenza _____
Tonsillitis _____Sinusitis _____
Frequent colds _____ Kidney Problems _____
Visual difficulties _____
Head injury (car accidents, sports, etc.) _____
Other: _____

_____

C. Did the child pass a newborn hearing screening?

Yes_____ No_____ Unsure_____