DELAWARE SPEECH & HEARING CENTER

CASE HISTORY INFORMATION – AUDIOLOGY – CHILD (R) 1/2016

YOUR APPOINTMENT IS ON _____ at _____

Office: ___ Grady Memorial Hospital (561 W Central Ave) ___ 494 W Central Ave; Delaware ___ 3940 N Hampton Dr; Powell

Please call 740-369-3650 if you need to cancel or reschedule your appointment

PLEASE COMPLETE ALL OF THE ENCLOSED FORMS & BRING THEM TO YOUR APPT ALONG WITH INSURANCE CARD(S), PHOTO IDENTIFICATION, AND LIST OF MEDICATIONS Including Dosage Instructions.

How did you hear about us? _____

Who can we thank for referring you? _____ Address _____

Child's Name: _____ Birthdate: _____ Age: _____

Address: _____ Male Female

City_____ Zip_____ County_____

****

Mother's Name: _____ Birthdate: _____ Occupation: _____

Address: _____ City _____ Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

(H) Ok to leave message (W) Ok to leave message (Cell) Ok to leave message

Employer:_____ Email Address:_____

Would you like to receive our newsletter? Y N Electronic Mail

****

Father's Name: _____ Birthdate: _____ Occupation: _____

Address: _____ City _____ Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

(H) Ok to leave message (W) Ok to leave message (Cell) Ok to leave message

Employer: _____ Email Address: _____

Would you like to receive our newsletter? Y N Electronic Mail

****

Person completing form/relationship_____

What concerns you most? ____Hearing Loss ____Speech/Language Development ____History of Ear Infections

Please describe the problem_____

When did you first notice the problem?_____

Has any treatment/services been tried ?_____

What were the results of the treatment/services?_____

Do you have a family history of hearing loss? _____Yes _____No Who?_____

HAS THE CHILD EVER HAD:

A Severe fall	Yes	No	A fever over 104	Yes	No
A blow to the head	Yes	No	An ear infection	Yes	No
Allergies	Yes	No	Ear surgery (tubes, etc)	Yes	No
Pain in the ear(s)	Yes	No	Tonsils or adenoids removed	Yes	No
Dizziness	Yes	No	Draining ear(s)	Yes	No

HISTORY OF PREGNANCY/DELIVERY:

Health of mother during pregnancy_____ Length of Pregnancy _____

Were there any complications with the pregnancy, labor, or delivery?_____

Birth weight_____ Any birth injuries?_____

Age of first words_____ Newborn Hearing Screening Results ___ Pass ___ Fail