DELAWARE SPEECH & HEARING CENTER
CASE HISTORY INFORMATION – AUDIOLOGY – Pediatric **(R) 10/2018**

APPOINTMENT DATE: _____ TIME:_____ **Please call 740-369-3650 to cancel or reschedule.**

☐ 494 W Central Ave; Delaware ☐ 3940 N Hampton Dr; Powell

BRING COMPLETED FORMS, INSURANCE CARD(S), PHOTO ID, & MEDICATION LIST TO YOUR APPOINTMENT.

Child's Name: _____ Age: _____ DOB:_____ ☐ Male ☐ Female

Primary Concern: Speech/Language Development *Other*: _____

When did you first notice this: _____

Currently enrolled in therapy or other services: No Please list services and providers:_____

_____

Pediatrician Name:_____ Phone: _____ Fax: _____

Pediatrician Address: _____

****

Custodial Parent's Name: _____Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

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

Employer:_____Email Address:_____

Ok to leave message ☐ Home ☐ Work ☐ Cell Would you like to receive our newsletter? No

Person completing form/relationship_____

****

PREGNANCY / BIRTH HISTORY:

Length of pregnancy (weeks): _____ Birth Weight: _____ Birth hospital: _____

Please list any complications/health issues during pregnancy or delivery, including ANY medications or drugs taken:

_____

_____

NICU stay: No If yes, how long and why? _____

_____

Newborn Hearing Screening results: Right: Fail Left: Fail

Which hospital performed the hearing screening?:

Family history permanent hearing loss in childhood: No If yes, please list:

ILLNESSES / ACCIDENTS:

☐ Chickenpox	☐ Cytomegalovirus (CMV)	☐ Diabetes	☐ Encephalitis	☐ Meningitis
☐ Measles/Rubella	☐ RSV	☐ Sickle Cell	☐ Concussion	☐ Allergies
☐ Dizziness	☐ Ear drainage	☐ Ear Infection	☐ Ringing in ears	☐ Fever over 104

Please list any hospitalizations, surgeries, or other medical diagnosis:

Please list current medications with dosage: