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: *Hearing Loss* *Speech/Language Development* *Other*: _____

When did you first notice this: _____

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

_____

Pediatrician Name:_____ Phone: _____ Fax: _____

Pediatrician Address: _____

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Custodial Parent's Name: _____Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

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

Employer:_____Email Address:_____

(H) Ok to leave message (W) Ok to leave message (Cell) Ok to leave message Would you like to receive our newsletter? Yes No

Person completing form/relationship_____

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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: Yes No If yes, how long and why? _____

_____

Newborn Hearing Screening results: Right: Pass / Fail Left: Pass / Fail

Which hospital performed the hearing screening?: _____

Family history permanent hearing loss in childhood: Yes 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: _____

_____