The Kaplan Hearing Center

8818 Centre Park Drive, Suite 107
Columbia, MD 21045
(410) 740-4885

Pediatric/Child Case History

Patient name: _____ Date of birth: _____ Age: _____

Referred by: _____

Reason for today's visit:

____ Speech/language delay ____ Failed hearing screening

____ Newborn hearing screening

____ Other (please explain): _____

Has your child had a hearing test before? Yes No

Is there a history of childhood hearing loss in the family? Yes No

Has your child had ear infections? Yes No
If so, how many and date of most recent infection: _____

Has your child ever had ear surgery? Yes No
If so, please explain: _____

Please list any current medications your child is taking: _____

Please check all that apply:

____ Premature birth ____ Chronic illness (please explain):

____ Developmental delay _____

____ Oxygen required at birth

____ Low birth weight (under 5 lbs.)

____ Failed newborn hearing test

____ Pediatric intensive care at birth

Any additional comments or information that you would like us to know:

_____

Parent/Guardian signature: _____Date: _____