Miller Speech and Hearing Clinic

Texas Christian University
P.O. Box 297450
Fort Worth, Texas 76129

CHILD HEARING CASE HISTORY

Date: _____
Person completing form:_____

IDENTIFYING INFORMATION:

Name: _____ Gender: M or F
Last First Middle

Date of Birth: _____ Age:_____ Primary Language: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Legal custodian:_____

Family members in household: _____

What do you expect from today's appointment? _____

How would you prefer information to be delivered?_____Verbal _____Written _____Pictures

HEARING & DEVELOPMENT HISTORY:
Primary Concern: _____

Referral Source: _____ Occupation: _____

How do you feel that your child hears? _____
Y N Unk Did your child have a newborn hearing screening? Where:_____
Results:_____

Y N Unk Is there a family history of childhood hearing loss? Who: _____

Y N Unk Has your child had a hearing evaluation before? When:_____
Where:_____ Results: _____

Y N Unk Does your child have hearing loss? Onset: _____
Type, Degree or severity of hearing loss: _____

Age of skills: Rolled over_____ Sat alone_____ Walked _____ 1st word _____

MEDICAL HISTORY:
Y N Unk Is there a history of ear infections? Last one: _____

Y N Unk Has your child had PE tubes? When: _____ ENT: _____

Y N Unk Does your child have seasonal allergies? Medications:_____

Y N Unk Has your child ever experienced dizziness? Explain: _____

Y N Unk Is your child currently taking medications? Name(s)_____
For what:_____

Has your child had any of the following illnesses or treatments and indicate at what age?

Tonsillitis _____ Tonsillectomy _____
Meningitis _____ Adenoidectomy _____
Head Injury _____ Hospitalizations _____
Frequent Colds _____ _____
Seizures _____ Surgeries _____
High Fever _____ _____
Mumps _____

Describe any other medical diagnosis or medical treatments _____

HEARING AID HISTORY: (If "no" to 1st question, please circle and move on to next section.)

Y N Unk Has your child ever used hearing aids? Age of fitting: _____

Y N Unk Does your child currently use hearing aids? Circle any of the following:

Ear: Right ear Left ear Binaural

Style: RITE BTE ITE ITC CIC

Make: _____

Dispensing location: _____

Y N Unk Are hearing aids used all waking hours daily? How many hours daily? _____hrs

Y N Unk Does your child use an FM system? Circle: Personal School
Model: _____

COCHLEAR IMPLANT HISTORY: (If "no" to 1st question, please circle and move onto next section.)

Y N Unk Des your child have a cochlear implant? Age of initial stimulation: _____

Ear: Right ear Left ear Bilateral

Manufacturer: Advanced Bionics Cochlear Med-El

Surgeon: _____ Implant Center: _____

Last mapping: _____ Model: _____

Y N Unk Does your child use an FM system? Circle: Personal School
Model: _____

AURAL REHABILITATION HISTORY:

Y N Unk Does your child participate in therapy for one of the following communication modes?

Auditory Verbal Auditory Oral Cued Speech Total Communication

Where: _____ Specialist: _____

The Miller Speech and Hearing Clinic shall not discriminate and provides services to our clients regardless of race, color, national origin, religion, gender, sexual orientation, age, disability, or political affiliation.