CARLS CENTER FOR CLINICAL CARE AND EDUCATION

CENTRAL MICHIGAN UNIVERSITY

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Pediatric Case History Form

Child's Name: ______________________ Appointment Date: ______________ MRN: __________________

Date of Birth: ____________________________ Age: _____________ Gender: ___________________

Primary Language Spoken in the Home: ________________ Other languages spoken: ___________________

Family Physician/Pediatrician: ______________________ Date last seen: ___________________________

Referring Physician (If different than above): ____

Name of Person Completing Questionnaire: ____

Relationship to child: ____

Reason for today's visit (your concern): ____

	Father's Information	Mother's Information
Full Name		
DOB		
Place of Employment		
Business Address		
Business Phone		
Position/Occupation		

Are the parents (please circle): Single Married Separated Divorced Foster Care Adoptive Deceased

Who has legal custody of this child? Name: ____

Relationship to child: ____

Address: ____ Phone: ___________________________

Other Children in the Family:

Name	Age	Does he/she have speech or hearing problems?

Patient Name: ________________________________ DOB: _______________________________________

Birth History

Age of mother during pregnancy: _____________ Length of pregnancy: _________ Child's birth weight: ________________

Did the mother experience any complications during pregnancy, labor or delivery, including illnesses, conditions, sexually transmitted disease(s), accidents, etc.? ☐ Yes ☐ No
If yes, please describe: ____

Was labor? (check one): ☐ Spontaneous ☐ Induced ☐ Cesarean Length of labor:______________ hours

Did the mother use tobacco or smoke during pregnancy? ☐ Yes ☐ No

If yes, number of cigarettes/uses per day: ____

Did the mother drink alcoholic beverages during pregnancy? ☐ Yes ☐ No

If yes, what was the frequency and amount consumed: ____

Did the mother use recreational drugs during pregnancy? ☐ Yes ☐ No

If yes, what drugs and how often: ____

Did the mother take any other medications during pregnancy (other than vitamins)? ☐ Yes ☐ No

If yes, what drugs and for what condition(s): ____

At birth, did the baby suffer from or experience any of the following complications (please check all that apply):

- ☐ **Jaundice**
- ☐ **Breech birth**
- ☐ **Low birth weight**
- ☐ **Blue Color**
- ☐ **Breath/respiratory difficulties**
- ☐ **Premature Birth**
- ☐ **Low APGAR score**
- ☐ **Infection of baby or mother**
- ☐ **Cesarean birth**
- ☐ **Sucking/swallowing difficulties**
- ☐ **Induced Labor**

Was your child given any medication at birth? ☐ Yes ☐ No

Was your child placed on any monitoring equipment at birth? ☐ Yes ☐ No

Was your child in the Neonatal Intensive Care Unit (NICU)? ☐ Yes ☐ No If Yes, How many days? _______________

How long was the baby in the hospital? ____

Did your child pass their Newborn Hearing Screening? ☐ Yes ☐ No If No, which ear referred: ☐ Right ☐ Left ☐ Both

Any other conditions or complications at birth: ____

____

Patient Name: ________________________________ DOB: _______________________________________

Medical History

Please list any doctors, clinic, schools, hospital or other agencies where you child has been seen:

Date of Last Appointment:	Type of Specialist:	Results:

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:

____

____

Allergies (food, medications, plastics, etc.): ____

____

Has the child experienced any of the following major medical conditions (please check all that apply):

☐ **Asthma**	☐ **Chicken Pox**	☐ **Frequent Colds**	☐ **Concussion**	☐ **Croup**
☐ **CMV*** (Cytomegalovirus)	☐ **Dizziness**	☐ **Draining Ear**	☐ **Measles**	☐ **Earaches or Ear Infections**
☐ **Encephalitis**	☐ **Exposure to Loud Noise**	☐ **Severe Headaches**	☐ **Hepatitis**	☐ **High Fever**
☐ **Influenza**	☐ **Mastoiditis**	☐ **Meningitis**	☐ **Mumps**	☐ **Pneumonia**
☐ **Rubella**	☐ **RSV*** (Respiratory Syncytial Virus)	☐ **Scarlet Fever**	☐ **Sinusitis**	☐ **Strep Infection**
☐ **Tonsillitis**	☐ **TB*** (Tuberculosis)	☐ **Cancer**	☐ **Heart Problems**	☐ **Other:_____________**

Current Medications (over the counter and prescriptions): _________________________________

____

Please check all medical symptoms that apply:

_____ Eye Problems (such as blurred vision, pain):
_____ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain)
_____ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations)
_____ Respiratory Symptoms (such as shortness of breath, cough, wheezing)
_____ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain)
_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)
_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)
_____ Psychiatric Issues (such as depression, anxiety, compulsions)
_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands)
_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency

Additional Comments: ____

____

Has the child been immunized? ☐ Yes ☐ No If yes, for which of the following (please check all that apply):

☐ Anthrax ☐ Influenza ☐ Rabies ☐ Chicken Pox ☐ Measles ☐ Rotavirus ☐ Diphtheria ☐ Meningococcus
☐ Rubella ☐ Hepatitis A ☐ Mumps ☐ Smallpox ☐ Hepatitis B ☐ Pertussis ☐ Tetanus ☐ Hib ☐ Pneumonia
☐ Zoster ☐ Human Papilloma virus ☐ Polio

Patient Name: ________________________________ DOB: ____

Hearing History

Has the child ever had a hearing test? ☐ Yes ☐ No If so, when? ____

Does the child experience hearing loss? ☐ Yes ☐ No ☐ Unsure If so, which ear? ☐ Right ☐ Left ☐ Both ☐ Unsure

If he/she does experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden ☐ Unsure

When did you first notice the child's hearing loss? ____

What do you think is the cause of the child's hearing loss? ____

Does the child have a history of ear infections? ☐ Yes ☐ No

If Yes, First occurrence: _____________________________ Frequency: ________________________________

Most recent ear infection: ___________________ Treatment(s): ______________________________________

Has the child ever had ear tubes surgically inserted? ☐ Yes ☐ No

If yes, when: ____

Has the child ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears

Does the child have a history of noise exposure? ☐ Yes ☐ No

If yes, please describe: ____

Please check all medical conditions that apply:

_______ Dizziness or Unsteadiness. If checked, is it accompanied by: ☐ Vomiting ☐ Nausea ☐ Ear Noises
_______ Ear Deformity. If checked, ☐ Right ear ☐ Left Ear ☐ Both ears
_______ Ear Drainage. If checked, ☐ Right ear ☐ Left Ear ☐ Both ears
_______ Ear Pain/Earaches. If checked, ☐ Right ear ☐ Left Ear ☐ Both ears
_______ Family History of Hearing Loss. If checked, who? ____
_______ History of Ear Wax Buildup
_______ Tinnitus/Ringing/Noises in ears. If checked, ☐ Right ear ☐ Left Ear ☐ Both ears
_______ Other, please describe: ____

Please check all that apply:

☐ My child has trouble hearing	☐ TV/radio is excessively loud	☐ My child tunes "in and out"
☐ There are sounds that make my child uncomfortable	☐ It helps my child when people speak loudly	☐ My child needs to hear instructions several times
☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school	☐ My child consistently responds to sounds	☐ My child consistently responds to his name
☐ My child consistently turns to loud sounds	☐ My child enjoys listening to music	

Patient Name: ________________________________ DOB: _______________________________________

Developmental and Educational History

Does the child's rate of development seem normal to you? ☐ Yes ☐ No

At what age was your child when they did the following?

Hold his/her head up alone: ___________________________

Sit alone without support: ____________________________

Crawl: ____

Walk unattended: ___________________________________

Feed themselves: ____________________________________

Become toilet trained: _______________________________

Babble: ____

Begin to say single words: ____________________________

Combine words into small sentences: ____________________

Use more complete sentences: _________________________

About how many words are in your child's vocabulary? _____________

Can you understand your child's speech? ☐ Yes ☐ No

Can other people understand your child's speech? ☐ Yes ☐ No

Does your child follow commands and directions? ☐ Yes ☐ No. If no, explain ____

____

Are you concerned about your child's speech and language development? ☐ Yes ☐ No. If yes, explain

____

Has the child ever been diagnosed with, or treated for any of the following:

ADHD/ADD: ☐ Yes ☐ No If yes, what medication(s) are they currently taking? : ___________________________________

Articulation/Speech Disorder: ☐ Yes ☐ No

Learning Disability: ☐ Yes ☐ No

Language Disorder: ☐ Yes ☐ No

Neurological Problems: ☐ Yes ☐ No

Physical Impairment(s): ☐ Yes ☐ No If yes, please describe: ____

Other (please specify): ____

Has your child undergone any of the below listed therapies?

Speech/Language Therapy: ☐ Yes ☐ No If yes, please describe: ____

Occupational Therapy: ☐ Yes ☐ No If yes, please describe: ____

Physical Therapy: ☐ Yes ☐ No If yes, please describe: ____

Vision Therapy: ☐ Yes ☐ No If yes, please describe: ____

Other (please specify): ____

Do you have any concerns regarding your child's social development and interactions with other children: ☐ Yes ☐ No

If yes, please describe: ____

Child's School: ____ Current Grade: ______________________________

Is the child enrolled in a special classroom setting? ☐ Yes ☐ No

If yes, please describe: ____

Does their classroom have an FM system? ☐ Yes ☐ No If yes: ☐ Personal ☐ Classroom

Is there any additional information you feel would be helpful for me to know when working with your child today?

____

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