Audiology Case History Form
Child

ARNOLD HEARING CENTRES

Child's Name: _____ DOB DD/MM/YYYY: _____

Parent/guardian name: _____ Date: _____

Reason for appointment: _____

Pregnancy or birth complications: ☐ Yes ☐ No

If yes, explain: _____

Passed infant hearing screening: ☐ Yes ☐ No ☐ N/A

Previous hearing test: ☐ Yes ☐ No If yes, when: _____

Family history of hearing loss: ☐ Yes ☐ No If yes, who: _____

Family history of ear infections: ☐ Yes ☐ No If yes, who: _____

Ear infections: ☐ Yes ☐ No If yes, when: _____

Ear Pain: ☐ Left Ear ☐ Right Ear ☐ N/A

Seen Ear Nose and Throat (ENT) specialist?: ☐ Yes ☐ No

If yes, please explain: _____

History of ear surgery:: ☐ Left Ear ☐ Right Ear ☐ N/A

Concussions/ traumatic brain injury: ☐ Yes ☐ No If yes, when: _____

Recent illness or congestion: ☐ Yes ☐ No If yes, when: _____

History of speech delay: ☐ Yes ☐ No

Assessed by Speech-language-pathologist?: ☐ Yes ☐ No If yes, when: _____

Difficulty hearing at home/school: ☐ Yes ☐ No

If yes, please explain: _____

Has sound sensitivity:: ☐ Yes ☐ No

If yes, please explain: _____

Special needs: _____

Medical conditions and medications: _____

Additional comments/ information:

_____

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