



Hoover Hearing Clinic  
A division of  
Hoover ENT Associates,  
P.C.  
2116 Data Park  
Hoover, Alabama 35244  
205-733-9694 Tel  
205-733-9599 Fax

Chart #: \_\_\_\_\_

### Child Case History

Name: \_\_\_\_\_ Age \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

1. Do you think your child has a hearing problem? \_\_\_\_\_
2. Has your child ever had a hearing test before? \_\_\_\_\_  
If yes, please report results: \_\_\_\_\_  
\_\_\_\_\_
3. Has your child had ear infections? \_\_\_\_\_  
If yes, how frequently: \_\_\_\_\_
4. Has your child ever had ear surgery? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
5. Please check any of the following your child may have a history of:  

|                  |               |                |                    |
|------------------|---------------|----------------|--------------------|
| Allergies        | Head Injuries | Meningitis     | Blood Transfusions |
| Encephalitis     | Chicken Pox   | Jaundice       | IV Antibiotics     |
| Serious Injuries | Measles       | Heart Problems | Oxygen Therapy     |
| Genetic Disorder | Mumps         | Syndromes      |                    |
6. Was the pregnancy for this child normal? \_\_\_\_\_  
Please explain any complications: \_\_\_\_\_  
\_\_\_\_\_
7. Was the delivery of this child normal? \_\_\_\_\_  
Was your child premature? \_\_\_\_\_  
Please explain any complications: \_\_\_\_\_  
\_\_\_\_\_
8. What hospital was your child born in? \_\_\_\_\_  
Did your child stay in the well-baby nursery or was your child in the neonatal intensive care unit (NICU)? \_\_\_\_\_

9. Please list all procedures and/or medications your child required at birth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Did your child pass the newborn hearing screening? \_\_\_\_\_  
If no, which ear failed? \_\_\_\_\_

11. Did your child pass all other health screenings administered at birth? \_\_\_\_\_

12. Does anyone on mother's or father's side of the family have a hearing loss? \_\_\_\_\_

13. Was anyone on either side of the family born with hearing loss? \_\_\_\_\_

14. Are there other children in the family? \_\_\_\_\_

15. Do you believe that your child's speech and language is developing normally? \_\_\_\_\_

16. Do you believe that your child is physically developing normally? \_\_\_\_\_

17. Does your child attend a day care center? \_\_\_\_\_  
Name of the day care center: \_\_\_\_\_

18. Does your child go to school? \_\_\_\_\_  
Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

19. Does your child require special educational services, such as speech therapy or remedial academic help? \_\_\_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_

20. Is there any additional information you would like to give regarding your child which you believe will be helpful? \_\_\_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_

21. Please provide names and addresses of other persons or agencies you would like this report to be mailed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_