PAEDIATRIC CASE HISTORY FORM

FULL NAME: **DOB:** **DATE:**

A. GENERAL INFORMATION

1. What is your main reason for attending the clinic?
2. What school year is the patient currently in? (Kindy/Prep/Year)
3. Please list any complications during pregnancy, at or after birth:

B. GENERAL HISTORY *(Please tick yes or no)*

1. Is there a history of hearing loss in your family, before the age of 50? ☐ **Yes** ☐ **No**
2. Did you child pass their newborn hearing screening? ☐ **Yes** ☐ **No**
3. Has your child ever had a formal hearing test done before? ☐ **Yes** ☐ **No**
4. Has your child reached all their developmental milestones to date? ☐ **Yes** ☐ **No**

   ***If NO**, please provide details:*
5. Has your child ever been diagnosed with a medical condition? (ADD/ADHD, Autism Spectrum Disorder, Specific Language Impairment) ☐ **Yes** ☐ **No**

   If YES, please describe:
6. Has your child ever been diagnosed with a serious illness? ☐ **Yes** ☐ **No**

   If YES, please describe:
7. Do you have any concerns with your child's reading, writing or spelling? ☐ **Yes** ☐ **No**
8. Does your child receive any additional school support? ☐ **Yes** ☐ **No**

C. MEDICAL HISTORY RELATED TO YOUR CHILD'S HEARING *(Please tick all that apply)*

☐ Ear pain	☐ Discharge	☐ Ear Infection, Date Last:
☐ Grommets, Date last:	☐ Perforation of the eardrum	☐ Blocked ear
☐ Tonsillitis	☐ Sinusitis	☐ Allergies
☐ Asthma	☐ Frequent colds	☐ Other:
☐ Ear Surgeries (Please list):		

D. HAS YOUR CHILD UNDERGONE ANY OF THE FOLLOWING ASSESSMENTS *(Please tick all that apply)*

☐ Optometry	☐ Occupational therapy	☐ Speech pathology
☐ Paediatrician	☐ Educational psychologist	☐ Other:

THANK YOU FOR ENTRUSTING US WITH YOUR FAMILY'S HEARING CARE

Save and Email your completed form to info@noosahearing.com.au
or print and bring it with you to your appointment.