WELLSTAR®
Medical Group

PEDIATRIC/NEWBORN CASE HISTORY

Child's Name:_____ Child's last name at birth:_____DOB:___/___/____
Sex: **Male or Female** Was the child pre-mature? **Y or N**

Which hospital was the baby born at?_____ Weight at birth?_____
Mother's name:_____ DOB: ____/____/_____

Father's name:_____DOB: ____/____/_____

Has the child had any previous hearing testing or screening? **Y or N**
If YES- where-when-what were the results?_____

Do you feel that your child can hear? **Y or N** **If YES**, how so? _____

Please answer yes (Y) or no (N):

	Illness or condition requiring admission to NICU for more than 48 hours?		Abnormalities of the child's ears/face/head?
	Any immediate family member with hearing loss or deafness?		Did the child have a blood transfusion due to Hyperbilirubinemia (Jaundice)
	Did mother of child have any infections during pregnancy such as Cytomegalo Virus, Herpes, Toxoplasmosis, Rubella?		Was the child on a ventilator for more than 5 days?
	Did the baby receive antibiotics more than 5 days while in the hospital?		Has the child had any trauma/injury to the head or ears?
	Have you been told that the child has any syndromes or neurological disorders?		Has the child had meningitis?
	Are you concerned about your child's hearing or speech & language development?		

What were the APGAR Scores at: 1 minute_____ 5 minutes_____

Current Medications: **Please write the name, strength, and how many times a day it is taken:**

_____

_____

Has the child had any ear infections or middle ear fluid? **Y or N**

If YES, How many?_____ **When was the most recent?**_____

Does the child currently have tubes in their ears? **Y or N** **If YES, how long?**_____

Has the child already been diagnosed with hearing loss? **Y or N** Does the child wear hearing aids? **Y or N**

If YES, what type, brand, and age of hearing aids?_____

Are the hearing aids working properly? **Y or N**

Please list the other physicians you would like for our practice to send the child's reports to (pediatrician, ETC):

Name:_____ **Name:**_____
Address:_____ **Address:**_____
_____ _____
Phone:_____ **Phone:**_____

I hereby authorize WellStar Audiology and Balance Center to release/discuss results regarding this child to any of the providers listed above. I also authorize WellStar Audiology and Balance Center to obtain medical, school, or agency records that may be needed for treatment.

Printed Name:_____ **Relationship to child:**_____
Signature:_____ **Date:**_____