



28 West 2nd Street
Duluth, MN 55802
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CASE HISTORY FOR HEARING EVALUATION

I. GENERAL INFORMATION

Date: _____

Child's Name _____ Date of Birth _____

Street Address _____ Phone _____

City/State _____ Zip _____

Does the child live with both parents? _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Who referred you to the Scottish Rite Clinic? _____

Brothers and Sisters (include names and ages—any speech, language or hearing problems?) _____

II. STATEMENT OF PROBLEM

Describe your concerns about your child's speech/language or hearing development. _____

What concerns do you or others have about your child's hearing? Has your child ever had his/her ears tested?

What other specialists has your child seen? Please list (physicians, audiologists, speech pathologists, teachers, etc.)?

IV. MEDICAL HISTORY

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies** _____ Asthma _____ Chicken Pox _____

Colds _____ Convulsions _____ Croup _____

Dizziness _____ Draining Ear _____ Ear Aches _____

Ear Infections _____ Encephalitis _____ German Measles _____

Headaches _____ High Fever _____ Influenza _____

Mastoiditis _____ Measles _____ Meningitis _____

Mumps _____ Pneumonia _____ Seizures _____

Sinusitis _____ Tinnitus _____ Tonsillitis _____

Other _____

**List allergies: _____

Describe any major accidents or hospitalizations _____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement, etc.)?

Is the child taking any medications? If yes, identify. _____

Have there been any negative reactions to medications? If yes, identify. _____

Have your child's ears been examined? _____ By whom? _____

Results of ear exam _____

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, is unduly frightened by loud sounds, etc.) _____

VI. SPEECH AND LANGUAGE

Does your child respond when his/her name is called? _____

Does your child seem to understand you? _____ Others? _____

How well do you understand your child? (*circle one*) Very well.....half the time.....Very little

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)? _____

Is your child getting any special services in the schools or from any other learning specialist? _____
