L.L. SCHENDEL
SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

AUDIOLOGY CASE HISTORY

(CHILD)

1. **Evaluation Date:** ________________________

2. **Client Name:** ____

   Client's Address: ____

   Guardian Contact Number: ____

3. **Accompanied by:** ____
   Name Relationship

4. **Age:** _______________________ **Date of Birth:** _______________________

5. **File number:** _______________________________

6. **Primary Clinician:** ____

7. **Secondary Clinician:** ____

8. **Referred by:** ____

1. **Reason for visit**: ____
____
____
____

2. **Previous hearing evaluations:** _____Yes _____No
   Where: ____
   When: ____
   Comments: ____
____
____

3. **Hearing loss:** ____Yes _____No
   _____Right Ear _____Left Ear _____Both Ears
   Is one ear better than the other? ______Right ______Left
   Age of onset: ______________
   Progressive? _____Yes _____No
Comments: ____

4. **Family History of Hearing Loss:**
   Relationship Age of Onset
   ___________________ __________
   ___________________ __________

Florida State University • 201 W Bloxham St •
Tallahassee, Florida 32306-1200
Telephone: 850.644.2238
Website: commdisorders.cci.fsu.edu

____________________ __________
____________________ __________
Comments: ____
____
____

5. History of Ear Infections: _____Yes _____No
Ear: _____Right _____Left _____Both
Age of Onset: ______________________________
Drainage? _____Yes _____No
Pain? _____Yes _____No
Treatment: ____
Comments: ____
____
____

6. Ear Surgery: ____Yes ____No
Ear: ____Right ____Left ____Both
Date(s): ____
Type(s): ____
Comments: ____
____
____

7. Tinnitus: ____Yes _____No
Ear: ____Right ____Left _____Both
Description: ____
Intensity: ____
Intermittent or constant? ____
Comments: ____
____
____

7. Dizziness:
Description: ____
Position related? ____
Nausea? ____
Time of Onset? ____
Frequency? ____
Has medical consultation been obtained? ____Yes ____No
Comments: ____
____
____

8. Head Injuries:
Date(s): ____
Loss of consciousness? ____
Hearing affected? ____
Comments: ____

____
____
____

9. Illnesses: (e.g., diabetes, kidney, circulatory/heart, infections)
____
____
____

10. Medications: ____
____
____
____

11. Noise Exposure History: Explain what happened, when this happened, and if hearing protection was worn.
____
____
____
____

12. Hearing Aid Use:
Ear Fitted: _____Right ______Left _____Both
First Worn: ____
Period Worn: ____
Benefit: ____
Comments: ____
____
____

13. Does your child turn up the television volume to a loud level?
____

14. Does your child have difficulty understanding speech on the telephone?
____

15. To your knowledge, has your child ever taken a medication that might affect their hearing? If so, when?
____
____