Health PEI
One Island Health System

Audiology
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Audiologie
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C.P. 2000, Charlottetown
Île-du-Prince-Édouard, C1A 7N8
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Paediatric Audiology Case History
All about your child . . .

Child's Name: _____ Gender: ☐ M ☐ F

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail: _____

Address: _____

Family Physician: _____

DAYCARE/PRESCHOOL/SCHOOL INFORMATION

Does your child participate in any of the following? If so, please specify:

☐ Day Care _____ ☐ Preschool _____

☐ School _____ Grade _____ Teacher _____

Describe progress in learning environment.

_____

_____

Language(s) used in the home: ☐ English ☐ French ☐ Other

PRIMARY CONCERNS

What are your current concerns about your child's hearing and how do they impact on your child's abilities? _____

_____

BACKGROUND INFORMATION

Do you feel your child has a speech problem?	☐ Yes	☐ No
Does your child have a hearing problem?	☐ Yes	☐ No
Is your child responsive to sound or voice?	☐ Yes	☐ No

Is there a family history of the following?

☐ Speech/language/ or hearing difficulties. Please describe. _____

_____

☐ Difficulties in school. Please describe. _____

_____

PREGNANCY AND BIRTH INFORMATION

During your pregnancy, did you:	YES	NO	Please Describe
• Have any illnesses or accidents?	☐	☐	_____
• Take any drugs (prescription or non-prescription) alcohol, or tobacco use?	☐	☐	_____
• Have any difficulty at time of birth?	☐	☐	_____

Length of Pregnancy _____ Child's Birth Weight: _____ lb _____oz

MEDICAL INFORMATION

Has your child had any of the following? Please check all that apply.

☐ tonsils/ adenoids removed	☐ allergies/anaphylaxis	☐ high fevers
☐ frequent ear infections	☐ head injury	☐ seizures
☐ reflux/ feeding difficulties	☐ surgery	☐ other
☐ middle ear tubes	☐ serious illness/ accident	
☐ asthma	☐ snoring/mouth breathing	

If yes, please provide more detail: _____

_____

Has your child ever been seen by:	YES	NO
A speech-language pathologist?	☐	☐
An audiologist or had a hearing test?	☐	☐
An ear nose throat (ENT) specialist?	☐	☐
Any other services?	☐	☐

If yes, please provide more details: _____

_____

Does your child take any medications? (Please list) _____

_____

DEVELOPMENTAL HISTORY

How old was your child when he/she . . .

Sat alone _____ Said first words _____

Walked alone _____ Put two or more words together _____

Parent / Guardian Signature:

_____ Date: _____

Personal information on this form is collected under section 31 _c_ of Prince Edward Island's *Freedom of Information and Protection of Privacy Act*, as it relates directly to and is necessary for the operations and delivery of the program. If you have any questions about this collection of personal information, you may contact the Health PEI FOIPP Coordinator by telephone (902) 368-4942.