



Child Case History

PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Guardians Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

Occupation (If applicable): \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Grp # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Grp # \_\_\_\_\_

How may we help you today? \_\_\_\_\_

Has your child ever had a hearing test before? \_\_\_ YES \_\_\_ NO
If yes, when and where? \_\_\_\_\_

FAMILY HISTORY

Parents related before marriage: \_\_\_ YES \_\_\_ NO Family history of thyroid problems: \_\_\_ YES \_\_\_ NO

Family history of hearing loss: \_\_\_ YES \_\_\_ NO History of stillbirths/miscarriages: \_\_\_ YES \_\_\_ NO

History of progressive blindness: \_\_\_ YES \_\_\_ NO Family history of kidney disease: \_\_\_ YES \_\_\_ NO

Mother worked outside home during pregnancy: \_\_\_ YES \_\_\_ NO If yes, where? \_\_\_\_\_

Father worked outside home during pregnancy: \_\_\_ YES \_\_\_ NO If yes, where? \_\_\_\_\_

MATERNAL FACTORS

Medications taken during pregnancy (including antibiotics): \_\_\_ YES \_\_\_ NO
If yes, specify: \_\_\_\_\_

Exposure to chemicals during pregnancy: \_\_\_ YES \_\_\_ NO
If yes, specify: \_\_\_\_\_

Exposure to radiation/chemotherapy during pregnancy: \_\_\_ YES \_\_\_ NO
If yes, specify: \_\_\_\_\_

Amniocentesis performed during pregnancy: \_\_\_ YES \_\_\_ NO

Rh immunoglobulin given; Rh or ABO incompatible \_\_\_ YES \_\_\_ NO

Illness during pregnancy: \_\_\_ YES \_\_\_ NO
If yes, specify: \_\_\_\_\_

Any paternal illnesses during pregnancy: \_\_\_ YES \_\_\_ NO
If yes, specify: \_\_\_\_\_

During pregnancy was mother exposed to: \_\_\_ Chickenpox \_\_\_ Measles \_\_\_ Mumps \_\_\_ German Measles

During pregnancy was mother diagnosed with: \_\_\_ Syphillis \_\_\_ Herpes \_\_\_ Influenza \_\_\_ Cytomegalovirus
\_\_\_ HIV/AIDS \_\_\_ Toxoplasmosis \_\_\_ Anemia \_\_\_ Diabetes



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**DELIVERY AND LABOR FACTORS**

Full-term pregnancy:  YES  NO If no, how many weeks early: \_\_\_\_\_  
Labor was induced:  YES  NO Labor was:  >3Hrs  <24 Hrs  
Premature membrane rupture:  YES  NO Bleeding:  YES  NO  
Forceps delivery:  YES  NO Cesarean section (C-section):  YES  NO  
Other unusual events: \_\_\_\_\_

**NEWBORN FACTORS**

Birth weight less than 5lbs  YES  NO APGAR score low at birth  YES  NO  
Placed in intensive care:  YES  NO Breathing problems at birth  YES  NO  
Oxygen given at birth  YES  NO Bilirubin >15mg/100ml  YES  NO  
Congenital rubella  YES  NO Defects of ear, nose, throat  YES  NO  
Congenital heart disease  YES  NO Exposure to chemicals  YES  NO  
Paralysis at birth  YES  NO Seizures at birth  YES  NO  
Septicemia  YES  NO  
Drugs given(inc. antibiotics)  YES  NO If yes, specify: \_\_\_\_\_

**INFANT/CHILDHOOD FACTORS**

Eye problems  YES  NO If yes, specify: \_\_\_\_\_  
Balance/gait/dizziness problems  YES  NO Cerebral palsy  YES  NO  
Seizures  YES  NO Seizures  YES  NO  
Head/skull injury  YES  NO If yes, specify: \_\_\_\_\_

**CHILD EVER HOSPITALIZED FOR/DIAGNOSED WITH/TREATED FOR:**

Meningitis  YES  NO Encephalitis  YES  NO Measles  YES  NO  
Diabetes  YES  NO Influenza  YES  NO Cytomegalovirus(CMV)  YES  NO  
Chickenpox  YES  NO Septicemia  YES  NO Sickle Cell  YES  NO  
Rubella  YES  NO

**HISTORY OF EAR PROBLEMS**

Ear infections:  NONE  LEFT  RIGHT  BOTH  
If yes, specify: \_\_\_\_\_  
Tube placement:  NONE  LEFT  RIGHT  BOTH  
If yes, specify: \_\_\_\_\_

HEARING ASSOCIATES OF NORTHERN VIRGINIA  
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**Patient Acknowledgement and Consent Form**  
**Acknowledgement of Notification**

The educational material entitled "Notice of Privacy Practices" provides information about how the Hearing Associates of Northern Virginia may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post the change in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, or health care operations. We are not required to agree to your restrictions: but if we do we are bound by our agreement with you.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure, including the following procedures; We educate our staff to keep information confidential; we discard protected information in appropriate containers or shred it; we require your written authorization prior to disclosing information to sources not identified in our privacy practices; you may revoke your written authorization at any time by sending us a written request.

*By signing below, you acknowledge that our Privacy Policy has been available to you.*

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\_\_\_\_\_  
Patient's Signature      Today's Day

**Consent for us and Disclosure of Information**

*By signing below, you consent to the use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.*

I request that payment of authorized Medicare or any other insurance carrier benefits be made on my behalf to the Hearing Associates or Northern Virginia for any services and/or products furnished to me by the health care specialist or supplier. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to provide all referral as required by my insurance carriers. All co-pays must be paid at time of services in accordance with the contracted insurance carrier agreements. All non-covered services and/or products must be paid for all the time the service is rendered or the product is dispensed.

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\_\_\_\_\_  
Patient Signature      Today's Date

