Michael LeMay, Au.D.
Doctor of Audiology

LeMay HEARING & BALANCE

Chelsea Comeaux, Au.D.
Doctor of Audiology

Pediatric Case History

Please complete this form and bring it with you to your child's appointment. If you have any questions or concerns about your child's hearing test, please contact **LeMay Hearing & Balance at www.LeMayAudiology.com.**

Child's Name _____ Date of Birth _____ Age _____

Father's Name _____ Mother's Name _____

Child's Pediatrician _____ Child's Doctor _____

Who referred you to LeMay Hearing & Balance? _____

Why was your child referred for a hearing test? _____

Has your child's hearing been tested before? ☐ Yes ☐ No

If yes, when and where was your child tested? _____

If yes, what were you told about the results of that test? _____

Has your child been tested for speech, motor skills, or other concerns? ☐ Yes ☐ No

If yes, what were you told about the results of those tests? _____

Does your child have a history of ear infections? ☐ Yes ☐ No

If yes, how frequently has (s)he had an ear infection? _____

If yes, when did the last ear infection occur? _____

What type(s) of treatment has your child been given for his/her infection(s)? _____

Is there a history of hearing loss in your family? ☐ Yes ☐ No

If yes, who had a hearing loss and at what age was their hearing loss identified? _____

Did any problems occur during the pregnancy or delivery of this child? ☐ Yes ☐ No

If yes, please describe. _____

Does your child receive any special services (such as speech therapy)? ☐ Yes ☐ No

If yes, please list all. _____

Please provide us with any additional background information that you believe would be helpful to us as we evaluate your child's hearing.