

CHILD CASE HISTORY FORM

Date:	Age:
Name:	

FAMILY HISTORY

- Family history of kidney disease Yes No Family history of thyroid problems Yes No
- History of progressive blindness Yes No History of stillbirths/miscarriages Yes No
- Other children with hearing loss Yes No
- Family history of hearing loss Yes No
- If yes, who? And when was the loss identified? _____

MATERNAL FACTORS

- Drugs 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
- Illnesses during pregnancy
If yes, specify: _____
- Anemia during pregnancy Yes No
- Diabetes during pregnancy Yes No
- Toxemia during pregnancy Yes No
- During pregnancy, was mother exposed to: Chickenpox Measles Mumps German Measles
- During pregnancy, was mother diagnosed with: Syphilis Herpes Influenza HIV/AIDS
 Toxoplasmosis Other: _____

DELIVERY AND LABOR FACTORS

- Full-term pregnancy Yes No If no, how many weeks early : _____
- Labour was induced Yes No Premature membrane rupture Yes No
- Labour less than 3 hours Yes No Bleeding Yes No
- Labour longer than 24 hours Yes No Forceps delivery Yes No
- Cesarean section (C-section) Yes No
- Other unusual events Yes No If yes, specify: _____

NEWBORN FACTORS

- Birth weight less than 5 pounds Yes No If yes, specify birth weight: _____
- APGAR scores low at birth Yes No If yes, APGAR score if known: _____
- Placed in intensive care Yes No If yes, specify how long: _____
- Breathing problems at birth Yes No
- Oxygen given at birth Yes No If yes, specify how long: _____
- Bilirubin > 15mg/100mL Yes No
- Congenital rubella Yes No
- Defects of ear, nose, throat Yes No If yes, specify: _____
- Congenital heart disease Yes No
- Drugs given (including antibiotics) Yes No If yes, specify: _____
- Exposure to chemicals Yes No If yes, specify: _____
- Paralysis at birth Yes No
- Seizures at birth Yes No
- Septicemia Yes No

INFANT/CHILDHOOD FACTORS

- Eye problems Yes No If yes, specify: _____
- Balance/gait/dizziness problems Yes No
- Cerebral palsy Yes No
- Seizures Yes No
- Head/skull injury Yes No
- Was your child ever hospitalized or treated for:
 - Meningitis Encephalitis Measles Influenza
 - Cytomegalovirus (CMV) Chickenpox Septicemia
 - Diabetes Sickle cell Rubella

HISTORY OF EAR PROBLEMS

- Ear infections: None Left Right Both
- If yes, specify what ages, how many, and how often: _____
- If yes, when was the last ear infection: _____
- Ever had "tubes" in ears? None Left Right Both
- If yes, specify when and how many times: _____