PROGRESS AFTER BIRTH

Feeding habits in early months:— (Normal) Slow Difficult

Sleeping habits, first year:— (Normal) Drowsy Cried a lot

Has your child:— Been vaccinated or immunised? NO (YES) Please give details
TWICE 3 IN 1 VAC HAS NOT HAD 3RD IS NOT ALLOWED TO HAVE WHOPPING COUGH DUE TO HAVING FITS.

Had any infectious disease? NO YES

Had any other illnesses, accidents or injuries? YES.

Been admitted to hospital? NO (YES)
Which hospital and for what reason?
ULSTER HOSPITAL & BELFAST ROYAL FOR SICK CHILDREN

If your child has been under any other Doctors for investigation, would you please give details:—
(R GLEADHILL ULSTER HOSPITAL & DR HICKS BELFAST ROYAL.

Has your child been away from you for more than a few days? [YES] HAS HAD EEG TWICE C.A.T SCAN, BLOOD TESTS ETC.

GENERAL DEVELOPMENT

At what age did your child: Sit up? 10 months Walk? NOT VERY STEADY

When did he:— Start to babble, saying "Dad-dad-dad-dad", "Ba-ba-ba"?
Start to say first words?
Use hand to hold a spoon to feed?

Which hand does he prefer to use? Right Left Either

Are movements:— Normal? Is he clumsy with:— Hands?
Unsteady? Feet?

At what age was he dry during the day? ✓

Have you any worries about your child's behaviour?

NO

If attending school, do you consider he is:— Having difficulties?
Getting on well?
Ahead of others in class?

Are there any subjects in which he:— Is outstanding?
Finds particular difficulty?

Has he had an intelligence test? NO YES If so, where?

Has he had his eyes tested? NO YES What was the result?

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090-019-035

Complete & Bring to clinic

CH 328770 Page: 3 of 5

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THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

Audiology Clinic

(If there is a choice of answer, please circle the correct one:—

e.g. (NO) YES SOMETIMES)

SURNAME OF CHILD: ROBERTS FIRST NAMES: CLAIRE MARGARE

DATE OF BIRTH: 10-1-87 SEX: FEMALE TELEPHONE NO: [redacted]

ADDRESS [redacted]

NAME & ADDRESS OF FAMILY DOCTOR:

N.H.S. Number:

By whom were you referred to the Audiology Clinic! Please give name and address:
[redacted] (HEALTH VISITOR)

Is your child attending (or has he attended) any of the following:—

	Date first went there	For how long each day	If Residential
Play group			
Nursery School			
Normal School			
School for the Deaf			
Partially Hearing Unit			
Other Special Unit *(Please give details)*			

IF OVER 16, STATE HOW EMPLOYED:

PARENTS

Father's Occupation:— [redacted]

Mother's Occupation:— [redacted]

At home all day. ✓
Goes out to work.
If so, how many hours a day?

What is your main worry about your child and in what way do you most want to help?

What is your own main worry about your child and in what way do you most want help?

Are there any other problems and difficulties which may be relevant?

CR - RVH

PRESENT COMPLAINT

Do you think your child is deaf? NO YES Since when?

Does he respond to:— NORMAL SOUNDS LOUD NOISES

YES YES

NO NO

SOMETIMES SOMETIMES

Have there been any other hearing tests? NO YES
Where and approximate dates:—
AUGUST 87

Is your child wearing or has he ever worn a hearing aid? NO YES
If so, what type?

Do you think your child is:— Late in talking? NO YES
Difficult to understand NO YES SOMETIMES

Did he start to talk and then leave off? NO YES At what age?

Can you think of any cause for these troubles?

Has he suffered from: Frequent colds? Earache?
Sore throats? Running ears?

090-019-036

FAMILY HISTORY

've you any other children? Please give age of each one and say whether Boy or Girl:—

[redacted]

Are any of them deaf? NO

Do any of them suffer from trouble dating from birth such as cleft palate or heart abnormality? NO

Is there any history of deafness in the family?
On Father's side:—
On Mother's side:— [redacted]

Were any of the other children late talkers:—

Is there any family history of late talking:—
On Father's side:— [redacted]
On Mother's side:—

Is the child Adopted? To be Adopted? Fostered?
Please give names of foster parents and Authority responsible:—

MOTHER'S HEALTH DURING PREGNANCY OF THIS CHILD

Did you have:—

German measles (Rubella)? If so, how many weeks pregnant?
If not, were you a contact?

Any other infectious disease? ... ... NO YES
Toxaemia? ... ... NO YES
Blood pressure? ... ... NO YES
Excessive vomiting? ... ... NO YES
Episodes of bleeding before the baby was due? ... ... NO YES

Did you take any medicines or pills? If so, what were they?

Did you have any other illness or accident whilst you were expecting this child?

DETAILS OF BIRTH

[redacted]

Date

CR - RVH

090-019-037

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

AUDIOLOGY CLINIC

Name Claire Roberts Hospital No. 328770 Date of Birth 10.1.87.

Address ..... Sex ..... Age .....

Referred by ..... School .....

Family Doctor ..... Religion .....

Date of Attendance 4/12/87 @ 11

RBHSC 20

Date			LEFT	RIGHT	
7/12/87	Distraction	Rattle	55-60 db	55 db.	11/12
		S	65 db.	55-60 db	
		chirebar	?60 db	60 db	
		voice	60-65 db	60-65 db.	

Referred GP — failed screening tests. May have hearing loss, but responds to loud sounds.

No ear symptoms

Rubble ++++

Puff Fits (on Epilim).

Ears TMs. dull, fluid.

Distraction levels 50-60 dBA.

T'grams — flat.

See ↑

?ECoG.

Date	
8.1.88	Mother thinks hearing fairly good Ear TMS pink T'grams - normal - final assessment 2/12
11.3.88	Mum feels v. much better[illegible] towards, "[illegible]" Passed [illegible] 2/12 ago TMS sats. Mother thinks hearing normal, [illegible] x 1 3/12 [illegible] MP Ears TMS
24.6.88	T'grams ✓ D.

Date	

CR - RVH

090-019-038