# Pediatric Hearing Questionnaire

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Date of Birth:</th>
<th>Gender: M / F</th>
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<tr>
<th>Parent(s):</th>
<th>Referred By:</th>
<th>Date:</th>
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<tr>
<th>School:</th>
<th>Grade:</th>
<th>Teacher:</th>
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<tr>
<th>School Room Setting:</th>
<th>Traditional</th>
<th>Open</th>
<th>Portable</th>
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Please check all that apply to your child. When asked, please describe the details.

## MEDICAL HISTORY

- □ Jaundice
- □ Measles
- □ Mumps
- □ CMV
- □ Head Trauma
- □ IV Antibiotics
- □ Ear Pain
- □ Ear Drainage
- □ Hole in the Eardrum(s)
- □ Middle Ear Fluid
- □ Patched Eardrum Hole
- □ Pressure (Ear) Tubes
- □ Hearing Loss
- □ Ringing in Ears
- □ Attention Deficit / Hyperactivity Disorder (AD/HS)
- □ Allergies
- □ Dizziness
- □ Sinus or Upper Respiratory Infections

- □ Meningitis: If yes, what type? Bacterial | Viral | Dates: |
- □ Family History of Hearing Loss or Hearing Difficulties?
  - If yes, who has these problems? □ Mother | □ Father | □ Sibling | □ Uncle | □ Aunt | □ Grandparent
- □ Chronic Ear Infections. If yes, total number and most recent episode:
- □ Previous evaluation by an ENT (ear, nose, & throat) physician? If yes, whom?
  - Physician Name: | City, State: |
- □ Previous Hearing Test: □ No | □ Yes | Location: | Date: |
- □ Results: □ Normal | □ Permanent Hearing loss | □ Temporary Hearing Loss
  - Right / Left / Both | Right / Left / Both | Right / Left / Both

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<tr>
<th>Current Primary Physician:</th>
<th>City, State:</th>
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## DEVELOPMENTAL HISTORY

- □ Was Newborn Hearing Screening Performed? □ No | □ Yes
  - Newborn Hearing Screening Results: □ PASS: Right / Left / Both | □ FAIL/REFER: Right / Left / Both
- □ Pregnancy Complications
  - □ Before Birth. Please describe: |
  - □ During Birth. Please describe: |
- □ Premature Birth If yes, how early? |
**EDUCATIONAL HISTORY**

- Has your child repeated a grade?  ☐ No  ☐ Yes.  *If yes, which one?*

- Child’s Favorite Subject:  

- Child’s Least Favorite Subject:  

- Academic Performance:  ☐ As & Bs  ☐ Bs & Cs  ☐ Cs & Ds  ☐ Failing  ☐ Mixture A - F

- Receives Tutoring:  ☐ No  ☐ Yes.  *If yes, please describe:*

- Has difficulty completing assignments:  ☐ No  ☐ Yes.  *If yes, please describe:*

- Has Difficulty with:  ☐ Spelling  ☐ Reading  ☐ Writing  ☐ Speaking  ☐ Math  ☐ Music

- Diagnosed with:  ☐ Dyslexia  ☐ Learning Disorder  ☐ Autism  ☐ Speech / Language Disorder  ☐ Sensory Integration problem

- Family History of:  ☐ Dyslexia  ☐ Learning Disorder  ☐ Autism  

  *If yes, who has these problems?*  ☐ Mother  ☐ Father  ☐ Sibling  ☐ Uncle  ☐ Aunt  ☐ Grandparent

**HEARING & LISTENING**

- Noise exposure.  *If yes, please describe:*

- Use of hearing protection in loud noise  ☐ Seems to hear but not understand

- Often asks “huh?” or “what?”  ☐ Asks for speakers to repeat themselves

- Talks loudly  ☐ Listens to TV / radio at high volume

- Sensitive to average or loud sounds  ☐ Startles to loud sounds

- Difficulty hearing in noise  ☐ Difficulty following multi-stage verbal directions

- Reverses numbers / letters  ☐ Does opposite of what is asked of him/her

- Difficulty remembering what is heard  ☐ Trouble determining location of sounds

- Misunderstands rapid / muffled speech  ☐ Difficulty discriminating speech sounds

Do **you** think your child has a problem with listening or understanding?  ☐ No  ☐ Yes

*If yes, please describe examples.*

Does your **child’s teacher** think your child has a problem with listening or understanding?  ☐ No  ☐ Yes  *If yes, please describe examples:*