



Pediatric Hearing Questionnaire

Name:	Age:	Date of Birth:	Gender: M / F
Parent(s):	Referred By:	Date:	
School:	Grade:	Teacher:	
School Room Setting:	<input type="checkbox"/> Traditional	<input type="checkbox"/> Open	<input type="checkbox"/> Portable

Please **check all** that apply to your child. When asked, please *describe* the details.

MEDICAL HISTORY		
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> CMV	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> IV Antibiotics
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Hole in the Eardrum(s)
<input type="checkbox"/> Middle Ear Fluid	<input type="checkbox"/> Patched Eardrum Hole	<input type="checkbox"/> Pressure (Ear) Tubes
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Attention Deficit / Hyperactivity Disorder (AD/HS)
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sinus or Upper Respiratory Infections
<input type="checkbox"/> Meningitis: <i>If yes, what type?</i> <input type="checkbox"/> Bacterial <input type="checkbox"/> Viral <i>Dates:</i>		
<input type="checkbox"/> Family History of Hearing Loss or Hearing Difficulties? <i>If yes, who has these problems?</i> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Grandparent		
<input type="checkbox"/> Chronic Ear Infections. <i>If yes, total number and most recent episode:</i>		
<input type="checkbox"/> Previous evaluation by an ENT (ear, nose, & throat) physician? <i>If yes, whom?</i> <i>Physician Name:</i> _____ <i>City, State:</i> _____		
Previous Hearing Test: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Location:</i> _____ <i>Date:</i> _____		
Results: <input type="checkbox"/> Normal	<input type="checkbox"/> Permanent Hearing loss	<input type="checkbox"/> Temporary Hearing Loss
<i>Right / Left / Both</i>	<i>Right / Left / Both</i>	<i>Right / Left / Both</i>
Current Primary Physician:		<i>City, State:</i>
DEVELOPMENTAL HISTORY		
<input type="checkbox"/> Was Newborn Hearing Screening Performed? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Newborn Hearing Screening Results: <input type="checkbox"/> PASS: <i>Right / Left / Both</i> <input type="checkbox"/> FAIL/REFER: <i>Right / Left / Both</i>		
<input type="checkbox"/> Pregnancy Complications		
<input type="checkbox"/> Before Birth. <i>Please describe:</i>		
<input type="checkbox"/> During Birth. <i>Please describe:</i>		
<input type="checkbox"/> Premature Birth <i>If yes, how early?</i>		

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<input type="checkbox"/> Low Birth Weight <i>If yes, what was weight?</i>			
<input type="checkbox"/> Low Apgar Score	<input type="checkbox"/> Meconium Poisoning	<input type="checkbox"/> Received (Mechanical) Oxygen	
<input type="checkbox"/> Speech or Language Delay	<input type="checkbox"/> Motor Developmental Delay		
<input type="checkbox"/> Receives Therapy: <i>(what kind?)</i>	<input type="checkbox"/> Speech / Language	<input type="checkbox"/> Occupational	<input type="checkbox"/> Physical
Other:			

EDUCATIONAL HISTORY					
Has your child repeated a grade? <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, which one?</i>					
Child's Favorite Subject:			Child's Least Favorite Subject:		
Academic Performance:	<input type="checkbox"/> As & Bs	<input type="checkbox"/> Bs & Cs	<input type="checkbox"/> Cs & Ds	<input type="checkbox"/> Failing	<input type="checkbox"/> Mixture A - F
Receives Tutoring: <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, please describe:</i>					
Has difficulty completing assignments: <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, please describe:</i>					
Has Difficulty with: <input type="checkbox"/> Spelling <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Speaking <input type="checkbox"/> Math <input type="checkbox"/> Music					
Diagnosed with: <input type="checkbox"/> Dyslexia <input type="checkbox"/> Learning Disorder <input type="checkbox"/> Autism					
<input type="checkbox"/> Speech / Language Disorder <input type="checkbox"/> Sensory Integration problem					
Family History of: <input type="checkbox"/> Dyslexia <input type="checkbox"/> Learning Disorder <input type="checkbox"/> Autism					
<i>If yes, who has these problems?</i> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Grandparent					

HEARING & LISTENING	
<input type="checkbox"/> Noise exposure. <i>If yes, please describe:</i>	
<input type="checkbox"/> Use of hearing protection in loud noise	<input type="checkbox"/> Seems to hear but not understand
<input type="checkbox"/> Often asks "huh?" or "what?"	<input type="checkbox"/> Asks for speakers to repeat themselves
<input type="checkbox"/> Talks loudly	<input type="checkbox"/> Listens to TV / radio at high volume
<input type="checkbox"/> Sensitive to average or loud sounds	<input type="checkbox"/> Startles to loud sounds
<input type="checkbox"/> Difficulty hearing in noise	<input type="checkbox"/> Difficulty following multi-stage verbal directions
<input type="checkbox"/> Reverses numbers / letters	<input type="checkbox"/> Does opposite of what is asked of him/her
<input type="checkbox"/> Difficulty remembering what is heard	<input type="checkbox"/> Trouble determining location of sounds
<input type="checkbox"/> Misunderstands rapid / muffled speech	<input type="checkbox"/> Difficulty discriminating speech sounds
Do you think your child has a problem with listening or understanding? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>If yes, please describe examples:</i>	
Does your child's teacher think your child has a problem with listening or understanding?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please describe examples:</i>	

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