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Pediatric Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

1. Is there a history of family hearing loss? YES NO

2. Does your child have permanent hearing loss that you are aware of? YES NO

Please describe such known loss: \_\_\_\_\_

3. Has any member of your family, or your child's teacher, ever expressed concern about your child's hearing ability? YES NO

4. Has your child had a formal hearing test by an Audiologist? YES NO

5. Does your child have a history of ear infections? YES NO

6. Does your child continue to have ear infections? YES NO

If yes, how many does he/she experience each year? YES NO

When was the most recent ear infection? \_\_\_\_\_

7. Has your child ever been seen by an Ear Nose and Throat specialist? YES NO

If so, the Doctor's name: \_\_\_\_\_

8. Has your child ever received tubes for chronic ear infections? YES NO

9. At what age did your child say his/her first word? \_\_\_\_\_

... start crawling? \_\_\_\_\_

... start walking? \_\_\_\_\_

10. Are there any academic concerns? YES NO

11. Was the pregnancy with this child free of complications? YES NO

If no, please explain: \_\_\_\_\_

12. Has your child suffered any serious illnesses? YES NO

If yes, please explain: \_\_\_\_\_

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