Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"

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Pediatric Hearing Questionnaire

Name:	Age:	Date of Birth:	Gender: M / F
Parent(s):	Referred By:		Date:
School:	Grade:	Teacher:	
School Room Setting: ☐ Traditional	☐ Open	☐ Portable	

Please <u>check all</u> 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*

Current Primary Physician: *City, State:*

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?*

☐ Low Birth Weight *If yes, what was weight?*

☐ Low Apgar Score ☐ Meconium Poisoning ☐ Received (Mechanical) Oxygen

☐ Speech or Language Delay ☐ Motor Developmental Delay

☐ Receives Therapy: *(what kind?)* ☐ Speech / Language ☐ Occupational ☐ Physical

Other:

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:*