Child Hearing Questionnaire

Please circle Yes, No and add any comments you feel may be helpful to the Audiologist

1. Does your child ask you to repeat frequently (ask "What did you say?") Yes No
   How long have you noticed the problem? _____
2. Listen to things loudly or ask for things to be turned up? Yes No
3. Complain of pain or tug at the ears? Left Right Pain Pressure
4. Any drainage from the ears? Yes No
   What color? Clear Bloodyother
5. Was a hearing screening performed at birth or any time after? Yes No
6. Complain of noise in the ears or head? Left Right Head
7. Does child wear hearing aids? Left Right Both
   How long have they worn these hearing aids? _____
   Where did you get them? _____
8. Complain of dizziness? Yes No
   When? _____
   For how long? _____
   Do you notice that they stumble when walking or have frequent falls? Yes No
9. Have they fallen or hit their head FOR ANY REASON? Yes No
   When? _____
   Were they unconscious? Yes No
   Did they go to the ER or see a physician? Yes No
   Who? _____
10. Have they ever had surgery on their ears? Yes No
    How long ago? _____
    What type of surgery? _____
    Where was the surgery done? _____
11. Have they ever had a hole in the eardrum? Yes No
12. Have they had any of these done of their head or ears?
    [ ] CT
    [ ] X-Rays

[ ] MRI

13. Have they been in any automobile accidents? Yes No
14. Is there ANY hearing loss on the mother's side of the family? Yes No
15. Is there ANY hearing loss on the father's side of the family? Yes No
16. Was their hearing loss:

[ ] Later in life or [ ] At birth

17. Are there any genetic disorders in your family? Yes No

If so, list: _____

18. Have you ever had genetic testing? Yes No
19. Has your child ever been treated for any life-threatening diseases? Yes No
20. Were antibiotics given by IV? Yes No

If so, list: _____

21. Have you or your child ever been hospitalized for any disease/infection? Yes No

If so, for what? _____

When? _____

22. Do you feel that your child understands when you ask them to perform simple tasks?

Yes No

23. Do you feel that they speak similar to children their age? Yes No
24. Does your child use words/vocabulary similar to their peers? Yes No
25. Do they use sentences? Yes No
26. Has your child ever repeated a grade level? Yes No

If so, which grade? _____

27. Were there any complications during the pregnancy? Yes No

If so, what? _____

Were there any complications during birth? Yes No

If so, what? _____

28. Does your child have any other complaints? Yes No

If yes, list: _____

_____

29. What physician referred you for the evaluation?

_____