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Pediatric Hearing Health Questionnaire

Patient Name: ____________________ Date of Birth___________ Today's date: _______

Referring Physician: ____________________

Reason for today's appointment: ____

Is child seeing or scheduled to see an Ear, Nose and Throat Physician? YES NO

Ear Health History

Are you concerned with your child's hearing?	YES	NO
Family history of hearing loss before the age of 30?	YES	NO
Pain or discomfort in ears?	YES	NO
History of ear infections or ear drainage?	YES	NO
Previous ear surgeries or scheduled for surgery?	YES	NO
Does your child consistently respond to your voice?	YES	NO
Does your child startle to loud sounds?	YES	NO
Can your child accurately locate sounds?	YES	NO
Has your child ever had their hearing tested before?	YES	NO

If yes, by whom, when and what were the results?: ______________________________

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Does your child wear hearing aids	YES	NO

PREGNACY AND BIRTH HISTORY

Birth weight: _______________ Term of pregnancy _______________ weeks

Where there any pregnancy or birth complications?	YES	NO
Did your child have a NICU stay?	YES	NO

If yes, how long ? ____________________________

Did your child pass their newborn hearing screen?	YES	NO