



Children's Hearing Questionnaire

General Information

Child's Name _____ Child's Birthdate _____

Guardian's Name(s) _____

How many siblings does the child have? ____ What are their ages? _____

Birth History

What was the child's birth weight? ____ Length of pregnancy? _____

If known, what was the child's Apgar score? _____

Did the mother have any of the following while pregnant for this child?

- | | |
|--|--|
| <input type="checkbox"/> Cytomegalovirus | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Syphilis | |

Where any medications given to the child at birth? If yes, please name _____

Did the child have bacterial meningitis? _____

Was the child on ventilation for 5 days or more? _____

Developmental Questions

Has the child had any type of head trauma? If yes, please explain _____

Has the child been diagnosed or suspected to have any type of disorder or syndrome? _____

Has this child had any ear infections? If yes, please explain _____

Do any of the child's blood relatives have a permanent childhood hearing loss? If yes, please explain _____

Does the child have any bone deformities? _____

Developmental Questions

1. Have you had any concerns regarding your child's hearing? Yes ___ No ___
2. When she is sleeping in a quiet room, does (s)he move or begin to wake when there is a loud sound? Yes ___ No ___
3. Does (s)he try to turn her/his head toward an interesting sound, or when her/his name is called? Yes ___ No ___
4. Is (s)he beginning to repeat some of the sounds that you make? Yes ___ No ___
5. By 15 months, can (s)he use three or four words correctly other than mama or dada? Yes ___ No ___
6. Can (s)he identify familiar pictures when you name them? Yes ___ No ___
7. Does (s)he name things when (s)he wants them (e.g., cookie)? Yes ___ No ___

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Sinus Disease
Sleep Disorders
Laser Surgery
Allergy Evaluation
Voice Disorders

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Audiology
Hearing Aid Sales
and Service
Balance Testing
and Rehabilitation