

PEDIATRIC QUESTIONNAIRE
PLEASE FILL OUT BOTH PAGES COMPLETELY

Patient Name: _____ SSN: _____

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> 5 minute APGAR 0-3 | <input type="checkbox"/> Jaundice (requiring transfusion) |
| <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Family History of Hearing Loss |
| <input type="checkbox"/> Congenital (TORCH) Infections | <input type="checkbox"/> Low Birthweight (less than 1500 grams or 4 lbs.) |
| <input type="checkbox"/> Defects of Head and Neck | <input type="checkbox"/> Two-Day Admission to Neonatal ICU |

Please answer the following as completely as possible.

Was the child's hearing screened in the hospital?

If so, did the child pass or fail?

Has any other testing or screening been done?

Does the child have a known hearing loss?

Is the child wearing hearing aids?

Does the child seem to have a fluctuating hearing loss (i.e. "selective hearing loss" or good/bad days)?

Does the child exhibit any balance or gait problems?

Does the child have any history of ear infections, sinus infections, or allergies?

If there is a history of ear infections, at what age did they begin?

How many have occurred?

How were they treated (antibiotics, placement of PE tubes, etc.)?

Is there any other medical history relevant to possible hearing loss?

Is there a family history of hearing loss?

If so, who?

Any history of head trauma?

Is there any history of unusual noise exposure?

Is the child exhibiting any speech or language problems?

Is the child exhibiting any behavioral or educational problems?

Is the child exhibiting any developmental problems?

Have any of these been diagnosed by a specialist?

Is the child receiving special education or any type of assistance in the classroom?

Do you as the parent/guardian feel the child has a hearing loss?

If so, why?

Who referred your child today?

Why?