Chesapeake Hearing Center—Pediatric Questionnaire

Patient Name:_____ SSN:_____

Check all that apply:

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

Please answer the following as completely as possible:

1. Who referred your child today, and why?
   _____

2. Do you as the parent/guardian feel the child has a hearing loss? YES or NO
   _____

3. Was the child's hearing screened in the hospital, and if so, did they Pass or Fail? PASS or FAIL

4. Does the child have a known hearing loss? YES or NO
   If yes, Is the child wearing hearing aids? YES or NO

5. Does the child seem to have a fluctuating hearing loss? YES or NO_____

6. If there is a history of ear infections, and at what age did they begin?_____
   If yes, how many have occurred and what was the treatment?_____

7. Is there family history of hearing loss? YES or NO
   If yes, who? _____

8. Is the child exhibiting speech or language delays or difficulties? YES or NO
   If yes, please explain_____

9. Has the child been diagnosed by a specialist? YES or NO
   If yes, please explain_____

10. Is the child receiving special education or any type of assistance in the classroom? YES or NO
    _____

11. Is there a history of, or exposure to any of the following? (If yes, please explain)
    - Unusual noise exposure? YES or NO_____
    - Head trauma ? YES or NO_____
    - Behavioral difficulties? YES or NO_____
    - Developmental delays? YES or NO_____
    - Balance or gait difficulties? YES or NO_____

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