

## Child History Questionnaire (2 Years to 17 Years)

Child's Name \_\_\_\_\_ Age \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_

Have we seen you at this office before?  YES  NO

Describe problem or reason for this evaluation: \_\_\_\_\_

Are you concerned about your child's hearing?  YES  NO If yes, explain: \_\_\_\_\_

Does your child have a hearing impairment?  YES  NO  UNKNOWN

Have you ever questioned your child's ability to hear normally?  YES  NO

If yes, please describe: \_\_\_\_\_

How long have you noticed this problem? \_\_\_\_\_

Is your child adopted?  YES  NO

If YES, from where? \_\_\_\_\_

Does your child know he/she is adopted?  YES  NO

### Birth and Prenatal History

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Premature?  YES  NO

Were there any complications during pregnancy or birth?  YES  NO

Length of pregnancy: \_\_\_\_\_ Length of labor: \_\_\_\_\_ Birth method: \_\_\_\_\_

At birth did the baby have the following: (please check)

Anoxia (blue color)  YES  NO      Respiratory distress  YES  NO

Jaundice (yellow color)  YES  NO      Stay in the hospital  YES  NO

Swallowing problems  YES  NO      Sucking problems  YES  NO

### Developmental Milestones

At what age did your child do the following? Sit alone \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Do you have any concerns with your child's development?  YES  NO

If yes, explain: \_\_\_\_\_

### Hearing History

Did your child pass their newborn hearing screening?  YES  NO

Has your child recently failed a hearing screening?  YES  NO

Has your child's hearing been tested since birth?  YES  NO

By whom? \_\_\_\_\_

When? \_\_\_\_\_

Where? \_\_\_\_\_

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**Does your child have hearing difficulty with: (Check all that apply)**

- One-on-one conversations    Group of people or multiple talkers    Women voices  
 Telephone conversations    Children's voices    TV volume  
 Small group conversations    Presence of background noise    Large group conversations  
 Other \_\_\_\_\_

**Check all that apply:**

- Inconsistent responses to sounds?    YES    NO  
Look when his/her name is called?    YES    NO  
Can hear but has problems understanding    YES    NO  
Turn toward loud sounds?    YES    NO  
Enjoy listening to music?    YES    NO  
Certain loud sounds make child uncomfortable?    YES    NO  
The child needs to hear instructions several times    YES    NO  
The child "tunes in and out" of listening situations    YES    NO  
My child's teacher has mentioned my child having trouble hearing in school    YES    NO  
Does your child experience tinnitus (ringing or buzzing) in your ears?    YES    NO

**If YES, please answer the questions below:**

- a) In which ear(s) do they experience tinnitus?    RIGHT    LEFT    BOTH  
b) How long have they experienced tinnitus? \_\_\_\_\_  
c) Is it high or low pitched? \_\_\_\_\_  
d) Is it a single noise or multiple sounds? \_\_\_\_\_  
e) Is it a pulsation or rhythmic quality? \_\_\_\_\_  
f) Is it constant or intermittent? \_\_\_\_\_  
g) If intermittent, how often and how long does it last? \_\_\_\_\_  
h) Do they notice tinnitus in quiet situations?    YES    NO  
i) Do you notice tinnitus in noisy situations?    YES    NO

**Child's Name** \_\_\_\_\_

- Has your child had recurrent middle ear infections?    YES    NO  
Has your child had medical or surgical treatment for their ears such as PE tubes?    YES    NO

Name of physician \_\_\_\_\_

Name of clinic \_\_\_\_\_

At what age(s) did treatment occur? \_\_\_\_\_

- Does he/she ever complain of pain or fullness in the ear?    YES    NO  
Has he/she ever been exposed to loud noises or an explosion?    YES    NO  
Does your child fall or lose balance easily?    YES    NO

Describe: \_\_\_\_\_

- Does your child use hearing devices?    YES    NO

If so, what type? \_\_\_\_\_

- Does your child use cochlear implants?    YES    NO

Name of physician \_\_\_\_\_

Name of clinic \_\_\_\_\_

When did treatment occur? \_\_\_\_\_

- Does your child use BAHA?    YES    NO

Name of physician \_\_\_\_\_

Name of clinic \_\_\_\_\_

When did treatment occur? \_\_\_\_\_

## Health History

Check all that apply:

- |                                                |                                                   |                                                       |                                                     |
|------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Excessive earwax      | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Articulation speech disorder | <input type="checkbox"/> Frequent colds             |
| <input type="checkbox"/> Vertigo               | <input type="checkbox"/> Language speech disorder | <input type="checkbox"/> High fevers                  | <input type="checkbox"/> Measles                    |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Draining ears            | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Attention deficit disorder |
| <input type="checkbox"/> Ear infections        | <input type="checkbox"/> Chickenpox               | <input type="checkbox"/> Autism                       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Scarlet fever         | <input type="checkbox"/> Asperger's syndrome      | <input type="checkbox"/> Sinusitis                    | <input type="checkbox"/> Meningitis                 |
| <input type="checkbox"/> Cerebral palsy        | <input type="checkbox"/> Mastoiditis              | <input type="checkbox"/> Seizures                     | <input type="checkbox"/> Encephalitis               |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Skull fracture           | <input type="checkbox"/> Migraine headaches           | <input type="checkbox"/> Impaired vision            |
| <input type="checkbox"/> Concussion            | <input type="checkbox"/> Other _____              |                                                       |                                                     |

Does your child have any open sores, bleeding or drainage at this time?  YES  NO

Describe: \_\_\_\_\_

Any other serious illnesses?  YES  NO \_\_\_\_\_

Any other serious surgeries?  YES  NO \_\_\_\_\_

Is he/she currently (or recently) under a physician's care?  YES  NO

Has your child been evaluated by any another medical specialist?  YES  NO

### Check all that apply:

- Pediatric neurologist  Developmental specialist  Chiropractor  Physical therapist  
 Occupational therapist  Audiologist (elsewhere)  Speech-language pathologist  
 Early intervention program

## Speech and Language Development

Which languages are spoken at home? \_\_\_\_\_

Primary language \_\_\_\_\_

Are you concerned about your child's speech and language development?  YES  NO

If yes, explain: \_\_\_\_\_

At what age did your child do the following? Babble \_\_\_\_\_ Imitate sounds \_\_\_\_\_ Say first word \_\_\_\_\_

Use two to three word phrases \_\_\_\_\_ Make complete sentences \_\_\_\_\_

About how many words are in your child's vocabulary? \_\_\_\_\_

Can you understand your child's speech?  YES  NO

Can other people understand your child's speech?  YES  NO

Does your child understand what you are saying?  YES  NO

Does your child follow commands and directions?  YES  NO

How does your child communicate with you? \_\_\_\_\_

Do you have any additional concerns or questions about your child's hearing communication skills or overall development? \_\_\_\_\_

## School Progress

Is your child in school?  YES  NO

Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

How would you describe your child's academic performance? \_\_\_\_\_



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