PARENT QUESTIONNAIRE

Child's Physician: _____ Phone # _____
Mailing Address: _____
Ear Specialist: _____ Phone # _____
Mailing Address _____

	NO	YES	(if yes, please explain)
Does your child have any medical concerns?	No	Yes	
Is there a family history of ear/hearing problems?	No	Yes	
Were there problems during pregnancy/delivery?	No	Yes	
Did your child fail the hearing screen at birth?	No	Yes	
Are there concerns about overall development?	No	Yes	
Has your child been hospitalized?	No	Yes	
Has your child had Meningitis?	No	Yes	
Has your child had a head injury?	No	Yes	
Does your child have allergies?	No	Yes	
Are there allergies in the family?	No	Yes	
Are there concerns about your child's hearing?	No	Yes	
Are there concerns in how your child responds to:			
Their name?	No	Yes	
The T.V.?	No	Yes	
Conversations?	No	Yes	
Listening in noise?	No	Yes	
Are there concerns about your child's speech?	No	Yes	
Does your child have frequent/severe colds?	No	Yes	
Has your child had ear infections or fluid build up?	No	Yes	
If so, approximately how many times?	No	Yes	
Has your child had surgery for ear problems?	No	Yes	
If so, what was done and when?	No	Yes	
Has your child had their tonsils/adenoids removed?	No	Yes	
Is your child on an IEP at school?	No	Yes	
If so, who is the case manager?	No	Yes	
Are there any concerns in school?	No	Yes	

AUDIOLOGIST'S NOTES