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?	☐	☐	
Is there a family history of ear/hearing problems?	☐	☐	
Were there problems during pregnancy/delivery?	☐	☐	
Did your child fail the hearing screen at birth?	☐	☐	
Are there concerns about overall development?	☐	☐	
Has your child been hospitalized?	☐	☐	
Has your child had Meningitis?	☐	☐	
Has your child had a head injury?	☐	☐	
Does your child have allergies?	☐	☐	
Are there allergies in the family?	☐	☐	
Are there concerns about your child's hearing?	☐	☐	
Are there concerns in how your child responds to:			
Their name?	☐	☐	
The T.V.?	☐	☐	
Conversations?	☐	☐	
Listening in noise?	☐	☐	
Are there concerns about your child's speech?	☐	☐	
Does your child have frequent/severe colds?	☐	☐	
Has your child had ear infections or fluid build up?	☐	☐	
If so, approximately how many times?			
Has your child had surgery for ear problems?	☐	☐	
If so, what was done and when?			
Has your child had their tonsils/adenoids removed?	☐	☐	
Is your child on an IEP at school?	☐	☐	
If so, who is the case manager?			
Are there any concerns in school?	☐	☐	

AUDIOLOGIST'S NOTES

MEDICAL:

Medication _____

Surgery _____

Other _____

EDUCATIONAL:

Academics _____

Classroom Concerns _____

Other _____

AMPLIFICATION: _____

OTHER: _____