DALLAS EAR INSTITUTE
PEDIATRIC HISTORY QUESTIONNAIRE

Patient Information

Patient Name:

Parents Full Names: _____

Birth History

How many weeks gestation was your child at birth? _____

What was your child's birth weight? _____

Was your child treated in the Neonatal Intensive Care Unit? Yes No

Did your child have an infection at birth? Yes No What kind? _____

Was your child treated with any antibiotics? Yes No What kind? _____

Was your child deprived of oxygen or had breathing problems? Yes No

If so, did he/she receive mechanical oxygen? Yes No

Did your child have elevated bilirubin (jaundice)? Yes No

Were any blood transfusions given? Yes No

Were there any congenital malformations of the head, neck or ears? Yes No

Did your child pass the newborn hearing screening in both ears? Yes No

Medical History

Has your child had any of the following:

Meningitis	Cytomegalovirus (CMV)	Measles	Mumps
Chicken Pox	Head Trauma	Allergies	Hole in the Eardrum
Ear Pain	Ear Infection	Ringing in the Ears	Dizziness
Ear Drainage	Ear Tubes		

Does your child have a sibling? Yes No

Is there a family history of hearing problems in childhood? Yes No If yes, whom? _____

Has your child ever had a surgical procedure? Yes No

If yes, what type? _____

Has your child ever seen an ear specialist? Yes No

If yes, whom? _____

Has your child had genetic testing? Yes No

Has your child had an MRI or CT scan of the ears? Yes No

Has your child ever seen a developmental pediatrician? Yes No

If yes, whom? _____

Does your child have a diagnosis or suspected diagnosis? Yes No If so, what? _____

_____

What medications does your child take? Name: Amount: How Often?

_____

_____

_____

_____

Does your child have any congenital malformations for the head, palate, ears, or neck? If so, what? _____

Hearing History

Do you think your child has a hearing problem? Yes No

How old was your child when you first noticed a hearing loss? _____

Has your child had a hearing test? Yes No If so, where? _____

When was your child's last hearing test? _____

Has your child been identified with hearing loss? Yes No

If yes, in the left ear, right ear, or both ears? _____

Does your child consistently respond to your voice? Yes No

At what age did your child say his/her first word? _____

How many words does your child have in his/her vocabulary? _____

Is your child's speech clear? Yes No

Are you here to rule out a hearing loss as a possible cause for a speech and language delay? Yes No

Does your child wear hearing aids? Yes No

If yes, when was your child first fit with hearing aids? _____

Where were the hearing aids purchased? _____

Does your child use a frequency modulation (FM) system in the classroom? Yes No

Does your child:

- Often asks "huh?" or "what?"
- Seems to hear, but not understand
- Talks loudly
- Difficulty discriminating speech sounds
- Misunderstands rapid/muffled speech
- Difficulty hearing in noise
- Listens to the TV/radio at a high volume
- Trouble determining location of sounds
- Sensitive to average or loud sounds
- Uses hearing protection around loud noises

Educational History

If school age, where does your child attend school? Grade? _____

Do you have any concerns about your child's progress in school? Yes No

Has your child repeated a grade? Yes No

Does your child receive preferential classroom seating? Yes No

Does your child's teacher think your child has a problem with listening or understanding? Yes No

Is there any other information about your child that is important for us to know? _____