# PEDIATRIC QUESTIONNAIRE

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient's Name: ___________________________</th>
<th>Date of Birth: ___________________________</th>
<th>Date(s) of Evaluation: ___________________________</th>
</tr>
</thead>
</table>

Signature of Patient/Parent/Guardian ___________________________ Relationship to Patient ___________________________

## PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

### Primary Care Physician/Pediatrician:
- **Address:**
- **City/State/Zip:**
- **Phone Number:**
- **Fax Number:** □

### ENT/Otolaryngologist:
- **Address:**
- **City/State/Zip:**
- **Phone Number:**
- **Fax Number:** □

### Hearing Aid Dispenser:
- **Address:**
- **City/State/Zip:**
- **Phone Number:**
- **Fax Number:** □

### Other:
- **Address:**
- **City/State/Zip:**
- **Phone Number:**
- **Fax Number:** □
Patient Name: ________________________  
Medical Record #: _____________________

PATIENT INFORMATION

Child’s First, Middle, Last Name: ________________________________________________________
Date of Birth: ____________________  Age: _________  Gender: ______________________________
Address: ________________________________________________________________
City: ___________________________  State: ______  Zip: __________  County: __________
Primary Language: __________________________  Other Languages: ______________________
Primary concern for this appointment: ________________________________________________
Who referred your child for this appointment? ________________________________________
Current diagnosis of child (list all): ________________________________________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian (A) Full Name: ________________________________________________________
  First  Last  (Maiden)
Date of Birth: ____________________  Race: ________________  Ethnicity: ____________________
Please Check:  Biological [ ]  Step [ ]  Foster [ ]  Adoptive [ ]  Other [ ]__________________
Primary Language: __________________________  Phone Number: ______________________
Email: ____________________________________________
Address __________________________________________  City ____________ State _____ Zip ______
[ ] check here if address is same as patient

Parent/Guardian (B) Full Name: ________________________________________________________
  First  Last  (Maiden)
Date of Birth: ____________________  Race: ________________  Ethnicity: ____________________
Please Check:  Biological [ ]  Step [ ]  Foster [ ]  Adoptive [ ]  Other [ ]__________________
Primary Language: __________________________  Phone Number: ______________________
Email: ____________________________________________
Address __________________________________________  City ____________ State _____ Zip ______
[ ] check here if address is same as patient

PREGNANCY, BIRTH, & HEALTH HISTORY

Child’s Place of Birth: _____________________________________________________________
Birth Weight: __________
Was your child born prematurely?  NO  YES  If yes, how many weeks? __________
Were there any complications during pregnancy or birth? ____________________________
Was your child cared for in the NICU/special care nursery? Why? ______________________
Was a Newborn Hearing Screening completed at birth? __________  Results: _______
Does your child have any allergies? Please list: ____________________________
Is your child taking any medications? Please list: ____________________________

**AUDIOLOGICAL HISTORY**

Do you think your child has a hearing problem? ______________________________
Has your child ever had a hearing screening at the pediatrician’s office? _____ Results? _______
Has your child ever had a complete hearing test before?  NO  YES
  Date/Location: ___________________________________________________________
Is there a history of middle ear infections/middle ear fluid? ____________________________
When was the last ear infection? ____________________________________________
Who has treated your child’s ear infections? How? ___________________________
*Is there a family history of childhood hearing loss? Please explain: ___________________________

**DEVELOPMENT HISTORY**

Do you have concerns regarding...
  ... your child’s speech and language?  NO  YES: ____________________________
  ... your child’s development?  NO  YES: ____________________________
  ... your child’s behavior?  NO  YES: ____________________________
  ... your child’s general health/nutrition?  NO  YES: ____________________________
Does your child receive any services through Early Intervention at home?  NO  YES
  ... if yes, what services? ____________________________________________
Have there been any recent changes in your child’s behavior/mood? ____________________________

**ACADEMIC HISTORY**

Current Grade Level: _________  School: __________________________________________
Are there any academic concerns/difficulties? If yes, explain: ____________________________

Has your child ever repeated a grade? If yes, which grade? ____________________________
Does your child receive any special accommodations/therapies at school?  NO  YES
  ... If yes, what services? ____________________________________________
  ... Does your child have an Individualized Education Plan (IEP) or 504 plan? __________
Does your child receive any private therapies/tutoring at home?  NO  YES: ____________________________