CHILDREN'S HEARING HISTORY

Name ____ Age _______ Birthdate ________________

Name of Family Physician ________________________ Who Referred You? __________________________

Do you think your child has a hearing problem? Yes ___ No ___ If yes, explain ________________________

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Has your child ever had earaches or ear infections? Yes ___ No ___

Has your child ever visited an ear doctor? Yes ____ No ____ Doctor's Name __________________________

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Has your child ever received medical treatment for a hearing problem? Yes ___ No ___ Explain ___________

____

Does any family member or relative have a hearing problem? Yes ___ No ___ If yes, please

Identify person(s) ____

Were there any serious problems experienced during pregnancy? Yes ___ No ___ If yes, please

explain____

Has your child had any high fevers that required the consultation of a doctor? Yes ___ No ____

Has your child had any contagious diseases? Yes ____ No ____ If yes, please name the disease(s)

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Do you think your child's speech is normal? Yes ___ No ___ If no, please explain _______________________

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Does your child attend school? Yes ____ No ____ Name __________________________________ Grade ____

Is your child experiencing any learning problems in school? Yes ____ No _____ If yes, please explain

____

Does your child wear a hearing aid? Yes _____ No _____

Who recommended a hearing aid for your child? ____

Where did you purchase the hearing aid? ____

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Signature of Person Completing Form Relationship to Child Date