Dr. G'Anne Thomas & Associates

Hearing & Balance Clinics

Advanced Care . . . Changing Lives.

Patient Name:______________________________ Date of Birth: __________________ Date: ___________________

Pediatric Patient Questionnaire

1. Child lives with:____.
2. Please state the reason for your visit: ____
   ____
   ____.
3. Names and ages of any other children in the home: ____
   ____.
4. Name and Address of the child's school, preschool, or child care setting: ___________________________
   ____.
5. Do you have any medical concerns about your child? If yes, briefly explain: ________________________
   ____
   ____.
6. List any prescription or over-the-counter medications your child is taking and for what reason(s):
   ____
   ____.
7. Has your child ever had surgery on his/her ears, nose, or throat? If yes, please explain:_____________
   ____.
8. Do you have any concerns bout your child's hearing? If yes, please explain: _______________________
   ____
   ____.
9. Please circle if your child has had any of the following. Briefly explain any that you have circled:

   Ear Infections   Ear Surgery   Hospitalizations   Head Trauma/Injury   Meningitis   Measles

   Mumps   Chicken Pox   Noise Exposure (e.g. farm equipment, loud music)

   Seizures   Kidney Problem   Vision Problems   Allergies   Asthma   Other

   explanation:____
   ____.

10. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?

    If yes, explain:____

    ____.

11. Does your child consistently respond to your voice? If no, explain: ________________________________

    ____.

12. Does your child respond to loud noises? If no, explain: ____

    ____.

13. When sound is present or someone is speaking, does your child search to find where the sound is coming from?

    ____.

14. Does your child respond to sounds from other rooms?______________________________________.

15. Does your child enjoy listening to music?____.

16. Has your child's hearing every been tested? If yes, by whom, when, results: _________________________

    ____.

17. Does your child wear hearing aid(s)? If yes, explain:____.

18. Does your child receive preferential classroom setting? If yes, explain:____________________________.

19. Was the pregnancy abnormal in any way? If yes, explain:_______________________________________

    ____.

20. Was the delivery abnormal in any way? If yes, explain: _______________________________________.

21. Was the delivery premature? If yes, explain: ____.

22. Did the mother have any illness during the pregnancy? If yes, explain:____________________________

    ____.

23. Did your child have any complications after birth? If yes, explain?_______________________________

    ____.

Signature:____ **Date:**__________________________

Printed name:____ **Relationship to patient:**________________