Laredo Hearing & Balance Solutions

10414 Medical Loop, Unit F
Laredo, TX 78045
Phone: 956-462-5848
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Pediatrics Questionnaire

1. Reason for your visit:

2. Referred by:

3. Child lives with: [ ] Both parents [ ] Mother [ ] Father [ ] Other

4. Do you have medical concerns for child: [ ] Yes [ ] No
   Explain: _____
   _____
   _____

5. Check if your child has had any of the following. Explain any that you checked.

   [ ] Ear Infections
   [ ] Ear Surgery
   [ ] Hospitalization
   [ ] Head Trauma/Injury
   [ ] Meningitis
   [ ] Measles
   [ ] Mumps
   [ ] Chicken Pox
   [ ] Noise Exposure (ex farm equipment,loud music)
   [ ] Seizures
   [ ] Kidney Problems
   [ ] Vision Problems
   [ ] Allergies
   [ ] Asthma
   [ ] Other

   Additional Comments: _____
   _____

6. Has your child ever had surgery on his/her ear(s), nose, or throat? [ ] Yes [ ] No

7. Do you have concerns about your child's hearing? If yes, explain. [ ] Yes [ ] No
   Explain: _____
   _____

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8. Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30? If yes, who? **Required [ ] Yes [ ] No
   Explain: _____
   _____

9. Does your child respond to loud noises? If no, please explain. [ ] Yes [ ] No
   Explain: _____
   _____

10. Does your child consistently respond to your voice? If no, please explain. [ ] Yes [ ] No
    Explain: _____
    _____

11. When sound is present or someone is speaking, does your child search to find where the sound is coming from? [ ] Yes [ ] No
    Explain: _____
    _____

12. Does your child respond to sounds from other rooms? [ ] Yes [ ] No

13. Does your child enjoy listening to music? [ ] Yes [ ] No

14. Has your child's hearing ever been tested? [ ] Yes [ ] No
    If yes, please list by whom, when, and results
    _____
    _____
    _____

15. Does your child wear hearing aid(s)? [ ] Yes [ ] No
    If yes, when was your child first fit? _____

16. Does your child receive preferential classroom seating? [ ] Yes [ ] No
    If Yes, please explain _____
    _____

17. Was the pregnancy abnormal in any way? [ ] Yes [ ] No

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If Yes, please explain _____
_____

18. Was the delivery abnormal in any way? [ ] Yes [ ] No
If Yes, please explain _____
_____

19. Was the delivery premature? [ ] Yes [ ] No
If Yes, please explain _____
_____

20. Did the mother have any illness during the pregnancy? [ ] Yes [ ] No
If Yes, please explain _____
_____

21. After birth, did your child have any of the following issues..
[ ] Breathing difficulties
[ ] Required an incubator
[ ] Any head, neck or ear abnormalities
[ ] Feeding problems
[ ] Surgery
[ ] Any infections requiring medication
[ ] Treatment for jaundice (yellow coloration of the skin)
[ ] Other
[ ] None of the above

Explanation: _____
_____
_____

22. Please list any medications taken by the mother during pregnancy:

_____

_____

_____.

23. Which hospital was patient born in?