Family Hearing Center
18 Westage Business Center Drive, Fishkill NY 12524
Tel: 845-897-3059; Fax: 845-897-3254

Child Questionnaire

Name: _____ DOB: _____

Address: _____ Parents: _____

_____ Phone: _____

Pediatrician: _____ Referred By: _____

Reason for Referral: _____

_____

Reports to be sent to (include mailing address or fax number): _____

_____

_____

School: _____ Grade Level: _____

BIRTH HISTORY:

Hospital of Birth: _____ Gestational Age (weeks): _____

Was your child adopted? Yes No Birth Weight: _____

Did your child have jaundice at birth? Yes No

If yes, was he/she treated with phototherapy? Yes No If yes, for how long? _____

Other complications? _____

_____

_____

Did your child spend time in the NICU? Yes No If yes, how long? _____

What treatments did he/she receive in the NICU? _____

_____

Medical History:

Has your child ever had an ear infection? Yes No If yes, how many/how often? _____

When was his/her last ear infection? _____

How were the ear infections treated? Antibiotics Tubes Other: _____

If tubes, when & how many sets? _____

Has your child had any surgeries? Yes No If yes, explain: _____

_____

Has your child ever been diagnosed with a medical condition? Yes No

If yes, explain: _____

(COMPLETE FORM ON REVERSE SIDE)

Is your child currently taking any medications? Yes No If yes, explain _____

Has your child had any fevers greater than 104˚F? Yes No If yes, when? _____

Is there a family history of hearing loss? Yes No If yes, who? _____

Type of hearing loss: _____

Developmental History:

Are there any delays in your child's development? Yes No

Motor Delays: _____

Speech Delays: _____

Other: _____

Has your child ever received any special services (i.e., Speech, OT, PT, etc.) Yes No

If yes, explain: _____

Is your child currently receiving any services? Yes No

If yes, explain: _____

Has your child's hearing been tested before? Yes No If yes, when? _____

Where? _____

What, if any, recommendations were made at that time? _____

_____

Does your child startle to a loud sound? Yes No

Have you observed your child reacting to a variety of sounds? Yes No

Please include any other information that you feel is important:

_____

_____

_____

_____

_____

_____

Insurance Information:

Insurance Co. _____ ID# _____

Name of Insured: _____ Date of birth: _____

Address (if different from above): _____

_____

Relationship to patient: _____

Employer: _____