**EAR·NOSE·THROAT SPECIALISTS**
*of Northern Virginia, P.C.*

**PROFESSIONAL HEARING SERVICES**
*The Dizziness and Balance Center*
*The Hearing Aid Center*

# PEDIATRIC QUESTIONNAIRE

Name: ______________________________ Referred by: ____________________

DOB: ______________ Age: ______ Pediatrician: ______________________________

How did you hear about us? ________________________________________

Reason for referral: ________________________________________

Hospital of birth: ________________________ Mother's maiden name: ________________

Was pregnancy/delivery of patient normal? ___ If "NO," explain: ______________________

________________________________________________________________

Was patient in NICU? ____ If so, how long? ______________________________

Is/was there a deformity of the ear? ______ Cleft lip? __________ Cleft palate? __________

Did patient pass his/her newborn hearing screening in the right ear? __________ In the left ear? __________

Has the patient experienced chronic ear infections? ________ If so, when was the last one? ______________

Has the patient had tubes placed in his/her ears? ________ If so, which ear(s)? ______________

Has the patient had any ear surgeries? ______________________________

Is there a family history of childhood hearing loss? ______________________________

Are there concerns regarding the patient's speech/language development? ______________________

If "YES," is the patient receiving therapy/services? ______________________________

Please report other significant medical history: ______________________________

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