Elizabeth Welch, Au.D.
Melinda Gray, Au.D.

Pediatric Questionnaire

Patient Name:____Date: __________________________________

Date of Birth:___________________________________Pediatrician: ____

What is the reason for your visit today? ____

1. Is there a history of family hearing loss? YES NO
2. Does your child have permanent hearing loss that you are aware of? YES NO

   Please describe such known loss: ____

3. Has any member of your family, or your child's teacher, ever expressed concern about your child's hearing ability? YES NO
4. Has your child had a formal hearing test by an Audiologist? YES NO
5. Does your child have a history of ear infections? YES NO
6. Does your child continue to have ear infections? YES NO

   If yes, how many does he/she experience each year? YES NO

   When was the most recent ear infection? ____

7. Has your child ever been seen by an Ear Nose and Throat specialist? YES NO

   If so, the Doctor's name: ____

8. Has your child ever received tubes for chronic ear infections? YES NO
9. At what age did your child say his/her first word? ____________________

   ... start crawling? ___________________

   ... start walking? ___________________

10. Are there any academic concerns? YES NO
11. Was the pregnancy with this child free of complications? YES NO

    If no, please explain: ____

12. Has your child suffered any serious illnesses? YES NO

    If yes, please explain: ____

3926 Dayton Blvd
Chattanooga, TN 37415

12136 South Main St.
Trenton, GA 30752

(423) 870-9930 Phone; (866) 258-2154 Fax