Loudoun County Public Schools
Pediatric Questionnaire for Audiologic Evaluation

Child's Name:	______________________	Date:	______________________
Address:	______________________	Sex:	Male Female
	______________________	Date of Birth:	______________________
Home Phone:	______________________	Age:	______________________
Cell Phone:	______________________	Pediatrician:	______________________
E-mail Address:	______________________	Clinic:	______________________

Statement of Problem

1. Reason for referral from LCPS:
   - Could not condition to task
   - Failed hearing screening with Child Find
   - Failed a hearing screening in school
   - Child has a known hearing loss
2. Do you have concerns regarding your child's hearing? Yes No
   a. If yes, list examples of what concerns you: ______________________
   ____
3. Has he/she ever worn a hearing aid? Yes No
   a. If yes, at what age were they fit with hearing aids? ______________________
   b. Make and Model of hearing aids? ______________________
4. Does your child have *extreme* reactions to new situations? Yes No
   a. If yes, please explain: ______________________
   ____
5. What language(s) is/are spoken in your home? ______________________

Medical History

6. Was he/she born premature? Yes No
   a. If yes, how many weeks premature? ______________________
7. Was your child placed in the NICU (neonatal intensive care unit)? Yes No
   a. If yes, why? ______________________
   ____
8. Was your child jaundice at birth? Yes No
   a. If yes, was your child treated by a blood transfusion? Yes No
   b. If yes, was your child treated with bili-lights? Yes No
9. Were there any abnormalities noted at birth? Yes No
   a. If yes, please explain: ______________________
10. **Did your child pass his/her newborn hearing screening?** Yes No
    a. What hospital was he/she born? ______________________

Child's Name:_______________________________________

11. Is your child currently on any medications? Yes No
    a. If yes, what medication and what is the reason for taking?_______________________________________

    ____
12. Has your child had more than one ear infection? Yes No
    a. If yes, how many?_______________________________________
    b. If yes, when was his/her last ear infection?_______________________________________
    c. If yes, how have the ear infections been treated?_______________________________________
13. Does your child suffer from seasonal allergies? Yes No
14. Do you notice any imbalance/dizziness/vertigo? Yes No
    a. If yes, please explain:_______________________________________
15. Has your child had an illness with high fevers (104ºF+)? Yes No
    a. If yes, please explain:_______________________________________

    ____
16. Has your child had surgery? Yes No
    a. If yes, please explain:_______________________________________

    ____
17. Please list any developmental delays in which you are concerned:_______________________________________

    ____
18. Additional comments:_______________________________________

    ____

Family History

19. Is there any history of hearing loss or deafness in the family? Yes No
    a. If yes, please explain:_______________________________________
20. Do you have any other children with speech and/or hearing problems? Yes No
    a. If yes, please explain:_______________________________________

Educational History (if currently enrolled in school only)

21. What grade are they in school?_______________________________________
22. Is he/she enrolled in Special Education? Yes No
    a. If yes, please explain:_______________________________________
23. Do any subjects cause particular difficulty? Yes No
    a. If yes, please explain:_______________________________________
24. Additional Comments:_______________________________________

    ____

    ____

Child's Name:____

Statement of Release

I, ____
Your Name Here

hereby request and/or grant permission to the above named Clinic to send a report of the diagnostic findings, evaluation, and therapy progress of this case to the following:

Pediatrician:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

ENT:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

Audiologist:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

Neurologist:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

School:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

Patient:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________

Other:
Name: ____________________
Address: ____________________
____
Phone: ____________________
FAX: ____________________
E-mail: ____________________