Lawrence Speech & Hearing Services

Youth Hearing Questionnaire

Patient Name: _____

What brought you into our office today? _____

_____

	Yes	No
Does your child wear hearing aids?		
Does your child consistently respond to your voice?		
Does your child respond to loud noises?		
Does your child enjoy listening to music?		
Does anyone in your family have night blindness?		
Does your child have a history of ear surgery?		
Does your child have a history of ear infections?		
Does your child respond to noises from other rooms?		
Does patient have a history of noise exposure?		
Has your child's hearing ever been tested?		
Does your child receive preferential classroom seating?		
Does your child lose their balance or fall easily?		
Does your child seem uncoordinated or clumsy?		
Does your child receive special education services?		
Do you feel your child is having difficulty in school?		
Does anyone in your family have a history of hearing loss that began before age 30?		

Person completing form:_____
Relationship to patient: _____

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