SOUTHSIDE HEARING CENTER

Child Medical Questionnaire

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE
REASON FOR TODAY'S HEARING EVALUATION		

(please circle one)

- Is there a **FAMILY HISTORY** of hearing loss? Yes No
- Do you as parent/guardian suspect that your child has a **HEARING PROBLEM**? Yes No
- Do you suspect or know of **SPEECH OR LANGUAGE DELAY**? Yes No
- Has the child been **EVALUATED FOR SPEECH / LANGUAGE DELAY**? Yes No
- Is your child currently receiving **SPEECH / LANGUAGE THERAPY**? Yes No

  If yes, how frequently? _____
- Is he/she receiving any other **INTERVENTION**? Yes No

  If yes, what? _____
- Is he/she making **ACADEMIC PROGRESS**? Yes No
- What **CONCERNS ARE THERE AT SCHOOL**? (include any attentional or behavioral issues, etc.)

  _____

  _____
- What **MEDICATIONS** does the child take? Please include over-the-counter medications._____

_____

_____
- Has your child had problems with, been treated for, or being currently treated for any of the following (please include surgeries, injuries, or traumas):

	YES	NO
EARS	☐	☐
NOSE	☐	☐
THROAT	☐	☐
NECK/THYROID	☐	☐
HEART	☐	☐
LUNGS/BREATHING	☐	☐
BLOOD PRESSURE	☐	☐
STOMACH	☐	☐
KIDNEY/BLADDER	☐	☐
SKIN	☐	☐
DIABETES	☐	☐

	YES	NO
BLOOD/BLEEDING	☐	☐
NEURO-PSYCH	☐	☐
MUSCLE/JOINT	☐	☐
ALLERGIES	☐	☐
IMMUNE DEFICIENCIES	☐	☐
HEPATITIS	☐	☐
TUBERCULOSIS	☐	☐
EYES	☐	☐
CANCER	☐	☐
JAW/TEETH	☐	☐
SINUS	☐	☐