Hearing Exam Guide for Families

Please complete form

Child's: Last name	First Name	Age
Doctor's Name:		Date of Exam:
Clinic Name / Hospital:		

Reason for making the appointment
❑ Noticed hearing problems ❑ Regularly scheduled appointment ❑ Referral / Physician suggestion ❑ Other: _____ Example: Teacher suggestion, Parent request

Family history of ear/hearing problems (especially at a young age):

Medications that the child is currently taking:

Other medical conditions that your child has been diagnosed with:

Questions that you want to be sure are answered at this appointment:

Does my child have hearing loss? If so, what kind?
❑ Sensorineural ❑ Conductive ❑ Mixed

Do you have more information about it or recommendations of where we can get more information?

Which ear is affected?	❑ Right	❑ Left	❑ Both

Audiological results:
Right _____
Left _____
Both _____

Is the hearing condition likely to:
❑ Improve
❑ Remain the same
❑ Deteriorate

Treatment:
Personal Amplifications – will they help?
❑ Yes
❑ No

	Right	Left	Both
Personal Amplification (Hearing Aids)			
Personal FM System			
Sound Field System			
Middle Ear Issues (ENT Referral, Tubes Recommended, etc.)			

Are there restrictions recommended in the child's activities?

Are there any symptoms that would signal the need for medical attention? (For example, in the case of LVA – Large Vestibular Aqueduct)

With a cochlear implant – will we need a safety plan? If so, what do we need to do?

Other Comments / Concerns?