



## HEARING QUESTIONNAIRE

Your child will receive a hearing screening by the school nurse annually during the primary grades and as needed during other years. Please inform the school nurse if you suspect your child is having problems with hearing.

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

***Please answer the questions below and return this form to the School Nurse.***

- |  |     |    |
|--|-----|----|
| 1. Does your child have a permanent hearing loss?  | YES | NO |
| 2. Does your child have a history of frequent ear infections?  | YES | NO |
| 3. In the past year has your child had middle ear fluid?   | YES | NO |
| 4. Do you think your child has difficulty hearing?   | YES | NO |
| 5. Is there a history of hearing loss in the immediate family?   | YES | NO |
| 6. Does your child have difficulty listening in a group situation or when background noise is present? | YES | NO |
| 7. Does your child need to watch you when you speak in order to understand what you say?               | YES | NO |
| 8. Has your child ever been examined by an ENT specialist?<br>If so, by whom? _____                    | YES | NO |
| 9. Does your child wear a hearing aid?   | YES | NO |
| 10. Does your child need hearing amplification in the classroom?                                       | YES | NO |

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date