



PROFESSIONAL HEARING SERVICES
THE DIZZINESS AND BALANCE CENTER

6231 Leesburg Pike, Suite 512, Falls Church, Virginia 22044, 703-536-1666
8644 Sudley Road, Suite 114, Manassas, Virginia 20110, 703-330-6636
150 Elden Street, Suite 235, Herndon, Virginia 20170, 703-707-0002
8314 Traford Lane, Lower Level, Springfield, Virginia 22152, 703-569-0355

PEDIATRIC QUESTIONNAIRE

NAME: _____ REFERRED BY: _____

DOB: _____ AGE: _____ PEDIATRICIAN: _____

Reason for referral: _____

Hospital of Birth: _____ Mother's Maiden Name: _____

Was pregnancy/delivery of patient normal? _____ If "NO" explain: _____

Was patient in NICU? _____ If so, how long? _____

Is/was there a deformity of the ear? _____ Cleft lip? _____ Cleft palate? _____

Did patient pass his/her newborn hearing screening in the right ear? _____ in the left ear? _____

Has the patient experienced chronic ear infections? _____ If so, when was the last one? _____

Has the patient had tubes placed in his/her ears? _____ If so, which ear (s)? _____

Has the patient had any ear surgeries? _____

Is there a family history of childhood hearing loss? _____

Are there concerns regarding the patient's speech/language development? _____

If "YES", is the patient receiving therapy/services? _____

Please report other significant medical history _____
