

Help Me Grow Hearing Status Questionnaire

Child's Name: _____
FIRST NAME LAST NAME

Early Track ID Number: _____

Subtract the **Child's Date of Birth** from **Today's Date** to calculate the **Child's Chronological Age**. Convert the chronological age into months for use with item 4 below.

Today's Date	(Year) _____	(Month) _____	(Day) _____
Child's Date of Birth	(Year) _____	(Month) _____	(Day) _____
Child's Chronological Age	(Years) _____	(Months) _____	(Days) _____
Child's Chronological Age in Months: _____ Months			

Completed By: _____
FIRST NAME LAST NAME

Signature: _____

Telephone Number: (____) _____ - _____ County: _____

PART I

YES	NO	Ask the child's parent or guardian the following three questions and check YES or NO for each.
<input type="checkbox"/>	<input type="checkbox"/>	1. Does the child have a diagnosed hearing loss?
<input type="checkbox"/>	<input type="checkbox"/>	2. Has the child seen an audiologist or an ENT physician within the last year?
<input type="checkbox"/>	<input type="checkbox"/>	3. (Under 6 mos.) Has a universal newborn hearing screening been completed? or (6 mos. or older) Has the child's hearing been screened or tested by a doctor or audiologist within the last 90 days?

If the parent/guardian answered **YES** to **any** of these three items, **STOP. Do not complete PART II.**
 If the parent/guardian answered **NO** to **all three**, continue to PART II.

PART II

YES	NO	Ask the child's parent or guardian each item. Check the box under the YES or NO column for each. Answer all items.	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diagnosed Medical Conditions? If yes, list:	
<input type="checkbox"/>	<input type="checkbox"/>	2. Risk Factors for Hearing Loss?	
<input type="checkbox"/>	<input type="checkbox"/>	In-utero infection(s)	
<input type="checkbox"/>	<input type="checkbox"/>	Postnatal infection(s)	
<input type="checkbox"/>	<input type="checkbox"/>	Neonatal indicator(s)	
<input type="checkbox"/>	<input type="checkbox"/>	Syndrome(s)	
<input type="checkbox"/>	<input type="checkbox"/>	Neurodegenerative disorder(s)	
<input type="checkbox"/>	<input type="checkbox"/>	Head Trauma	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infection(s)	
<input type="checkbox"/>	<input type="checkbox"/>	3. Blood Relatives with a permanent hearing loss under the age of 16?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cousin(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother's Mother
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother's Father
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother's Sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father's Mother
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father's Father
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father's Sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Behavioral Observations by Parent/Guardian
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Only ask the items at the child's Chronological Age or younger. For items older than the child's chronological age, mark 'N/A'.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 36 mos. - Recognizes different sounds (doorbell vs. phone)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 24 mos. - Points to some body parts on command
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 18 mos. - Responds when name is called
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 15 mos. - Reacts when music is introduced (turned on)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 10 mos. - Babbles (says things like "ba-ba-ba," "ma-ma-ma")
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 6 mos. - Turns head to search for a sound
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By 3 mos. - Startles to loud sounds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does the parent/guardian have any concerns regarding the child's hearing? If yes, list:

If any WHITE boxes in PART II are checked, REFER for a hearing screening or an audiologic evaluation by an audiologist or ENT physician.