Name: DOB:

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Yes** | **No** | **Not Sure** |
| 1. Are there any concerns about the child’s hearing?
 |  |  |  |
| 1. Is there any family history of hearing loss?

 Describe: |  |  |  |
| 3. Did a doctor refer the child for a hearing screening? |  |  |  |
| 4. Did the child have complications at birth? |  |  |  |
| 5. Was the child born premature? |  |  |  |
| 6. Was the child’s hearing screened at birth? What was the result? |  |  |  |
| 7. Has the child been hospitalized? |  |  |  |
| 8. Has the child had significant illness? Describe: |  |  |  |
| 9. Has the child had any ear infections? How many? |  |  |  |
| 10. Any ear infections in the past 6 months? |  |  |  |
| 11. Has the child been to an Ear/Nose/Throat Specialist? |  |  |  |
| 12. Does the child consistently respond to sounds at home? |  |  |  |
| 13. Does the child seem to understand what adults say? |  |  |  |
| 14. Does the child follow appropriate simple directions? |  |  |  |
| 15. Does the child respond to his/her name most of the time? |  |  |  |

Additional comments:

Form completed by: Date:

***After completing this checklist, please take this form to the child’s team for discussion/consideration***