

12. Does your child have any other associated disability? (Please circle)
- A. Blindness or vision disorder
 - B. Cerebral Palsy
 - C. Developmental disability
 - D. Seizure disorder
 - E. Down Syndrome
 - F. Learning disability
 - G. Other _____
13. When did you last consult a physician about your child's ears? _____
14. Has your child had any earaches? _____ Drainage? _____ Which ear? _____
15. Any medical treatment of your child's ears? _____
16. Has your child experienced any dizziness? _____
17. Is your child receiving any medication? _____

Hearing and Speech History

18. Do you think your child has a hearing problem? _____
19. How old was your child when you first noticed a loss of hearing? _____
20. Has your child's hearing been tested before? _____
21. Does your newborn baby startle to loud sounds? _____
22. Does your 3 month old stop moving or stop crying when you call him? _____
23. Does your 6 month old enjoy noise-making toys? _____
24. Does your 9 month old babble frequently? _____
25. Does your one year old respond to simple commands ("no no")? _____
26. At what age did your child babble? _____ First word _____
- Short (2-3 word) sentences? _____
27. How many words does your child have in his/her vocabulary? _____
28. Does your child's use speech frequently, occasionally, seldom or never? _____