Child's Hearing Questionnaire

Reception No.

Child's name（　　）
Child's date of birth (____year ___month ___day)
Your relationship to child　（　　）

☆ Please read the following questions about your child and circle the applicable answer.

Questions	Answers	
① Have any of your child's family/relatives been hard of hearing since they were very young?	no	yes
② Has your child ever contracted otitis media (inflammation of the middle ear)?	no	yes
③ Does your child often have nasal congestion, nasal drip, breathe through their mouth, or dry throat?	no	yes
④ Have you ever wondered if your child is hard of hearing due to not responding when called, asking you to repeat yourself, or watching loud television?	no	yes
⑤ Has anyone in close contact with your child (daycare staff, etc) ever said that your child is hard of hearing?	no	yes
⑥ Have you ever had any concerns about your child's speech being slow, having odd pronunciation, etc?	no	yes
⑦ Do you ever need to supplement your speech with gestures in order to be understood?	no	yes

☆ Whisper Test Results

Say the name of the picture 1 time only. Even if they ask you to repeat yourself, please do not repeat the word. Draw a circle under the words they answer correctly, and an X under the words they ask you to repeat or answer incorrectly.

dog	shoes	umbrella	elephant	cat	chair

(The below is for the use of Otsu General Health Center and may be left blank.)

Whisper hearing test:　☐ not needed　☐ necessary　（　　／ 6 ）