PATIENT NAME_____ DATE OF BIRTH_____

HEARING AND VISION RISK ASSESSMENT: 3 YEARS AND OLDER

Does your child:

1.	Have a problem hearing over the phone?	Y	N
2.	Have trouble following a conversation when two or more people are talking at the same time?	Y	N
3.	Complain that the volume needs to be turned up on the TV?	Y	N
4.	Strain to understand conversations?	Y	N
5.	Have trouble hearing in a noisy background?	Y	N
6.	Ask you to repeat yourself?	Y	N
7.	Misunderstand what others are saying and respond inappropriately?	Y	N
8.	Have trouble understanding the speech of women and children?	Y	N

Does or has your child:

1.	Ever had an eye exam?	Y	N
2.	Wear glasses or contacts?	Y	N
3.	If yes, when was their last exam?	DATE:_____	
4.	Hold toys or books close to their eyes?	Y	N
5.	Have trouble recognizing faces at a distance?	Y	N
6.	Tend to squint?	Y	N
7.	Failed a school vision screening test?	Y	N

(Below completed by Physician only)

COMMENTS: Hearing screen: NEEDED / NOT NEEDED

Refer to ENT: _____

Left Ear: PASS / FAIL Right Ear: PASS / FAIL

COMMENTS: Vision Screen: NO SCREENING NEEDED

RECHECK IN 6 MONTHS

Refer to Ophthalmology: _____

LEFT EYE: _____ RIGHT EYE: ____

Provider Signature: _____ Date: _____

Cartersville Pediatric Associates