Name of Child		Male・Female	Date of birth: year month day
Householder's name		TEL ― ―	
Address			
Date of examination	year month day (present age on day of examination years months)		

<QUESTIONNAIRE>

Please circle the applicable items as described below:

1	Is the child receiving any medical treatment of secretory otitis media?	No・Yes
2	Does he/she get otitis media frequently?	No・Yes (times)
3	Does he/she breathe with the mouth open	No・Yes
4	Does he/she usually snore?	No・Yes
5	Does he/she always have a runny or a blocked nose?	No・Yes
6	Are there any worries about his/her speech delay or pronunciation?	No・Yes
7	Can he/she speak 3-words-sentences?	Yes・No
8	Have you ever thought that the child has bad hearing?	No・Yes

(For example, "not responding even when called by name", "frequently repeating", "watching TV with high volume, or watching TV at a close distance" etc.)

<Hearing Test>

1 Finger rubbing audibility test:
At the right column, please write circle (○) if he/she has no problem hearing, X if he/she has problem hearing, triangle (△) if you do not know.

Right ear	Left ear

2 Whisper audibility test:
In the box below, please write circle (○) if the child points out the correct picture, and X if the child points out the wrong picture. Also, keep it blank if the examination could not be done.

【1st time】

TSUMIKI	JŪSU	KIRIN	UMA	OFURO	BŌRU

【2nd time】

TSUMIKI	JŪSU	KIRIN	UMA	OFURO	BŌRU

Please write down any inquiries or any noticeable points relevant to your child's audibility