Newborn Hearing Health History

Infant’s Name: ___________________________ Date of Birth: ______________________

Mother’s Name: ________________________ Father’s Name: ______________________

Siblings (Names & Ages): ________________________

Info Provided By: ________________________ Relationship to Child: ______________________

Pediatrician: ________________________

Background Information

Do you have concerns regarding your baby’s hearing? □ yes □ no
If so, please describe: ____________________________________________________________

Did your baby receive a newborn hearing screening? □ yes □ no
If so, what were the results? □ passed □ failed

Has your baby received any other evaluations since birth? □ yes □ no
If yes, please list: ________________________________________________________________

Is there a family history of hearing loss? □ yes □ no
Does your baby startle/respond to loud sounds (eye blink, cry, head turn)? □ yes □ no

Pregnancy History and Birth History

Length of Pregnancy (full term, premature, late): ________________________

Complications during pregnancy: ____________________________________________

Medications/drugs used during pregnancy: ______________________________________

Birth weight: ________________________ APGAR score (if known): ____________

Were there any delivery complications? □ yes □ no
If yes, please explain: __________________________________________________________

Was your baby in intensive care? □ yes □ no

Please list any medical conditions your baby has: ______________________________

Please list any medications your baby has received since birth: __________________

Other Important Information Not Provided Above

__________________________________________________________

Signature of Person
Providing Information: ________________________ Date: ________________________