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

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Signature of Person
Providing Information: ______________________ Date: ______________