NEWBORN CASE HISTORY

Patient's Name: ____

Date of Birth ____

1. Was your child born in a hospital or was this a home birth? ____________________________

2. Were there any complications during either birth or pregnancy? Yes No
If yes, describe: ____

3. What was the infant's birth weight?
_____lbs _____oz(s)

4. If known, what were your newborn's APGAR scores?
1 minute: _______ 5 minutes: _______ Not known _______

5. Was your newborn born prematurely? Yes No
If yes, how many weeks? _________________

6. Did your newborn pass a hearing screening in either ear in the hospital? Yes No
If yes, which ear? RIGHT LEFT BOTH

7. Do you have any overall concerns regarding your newborn's hearing? Yes No
If yes, please describe: ____

8. Has your newborn taken any medications since birth? Yes No
If yes, what? _____________________ Reason: _________________________

9. Are there any genetic disorders diagnosed in your newborn or family? Yes No
If yes, describe: ____

10. Please check if your newborn has experienced any of the following:

○ Family history of childhood hearing loss
○ Hyperbilirubinemia/Jaundice
○ Congenital infections
○ Exchange transfusion
○ Toxoplasmosis
○ Ventilator used in hospital
○ CMV How long? ____________
○ Syphillis
○ Asphyxia
○ Herpes
○ Head trauma
○ Rubella
○ Meningitis
○ Unusual head/neck features
○ Congenital diaphragmatic hernia

______________________________________ _________________
Signature of person completing history Date

___________________ Relationship to newborn