



Infant Hearing Health History

Infant's Name: _____ Today's Date: _____
Home Address: _____ Parent(s): _____
_____ Phone Number: _____
Date of Birth: _____ Age (months): _____ Gender: _____
Pediatrician: _____ Pediatric Group: _____
Sibling(s) (names & ages): _____
Information Provided By: _____ Relationship To Infant: _____
Referral Source: _____ Send Report To: _____

Background Information

Do you have concerns regarding your baby's hearing? yes no
If so, please describe: _____
Did your baby receive the Universal 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 so, what specialists? _____

Pregnancy

Length of Pregnancy (full term, premature, late): _____
Medications/Drugs Used During Pregnancy: _____
Frequency of Alcohol Use During Pregnancy: _____
Illnesses/Infections During Pregnancy: _____
Did you contract, or were you exposure to, any of the following during your pregnancy?
 Cytomegalovirus (CMV)
 Loop diuretics
 Chemotherapeutic drugs (cisplatin)
 Aminoglycocides