

## 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
Is there a family history of hearing loss? (parents, siblings, etc.)	yes	no
Has your baby received any other evaluations since birth?	yes	no
If yes, please list: _____		
Has your baby seen any of the following specialists?		
<input type="checkbox"/> Otolaryngologist (ENT)	<input type="checkbox"/> Geneticist/Genetic Counselor	
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Other: _____	

### Pregnancy History

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?

<input type="checkbox"/> Cytomegalovirus (CMV)	<input type="checkbox"/> High fever
<input type="checkbox"/> Industrial solvents (tolulene, styrene)	<input type="checkbox"/> Rubella
<input type="checkbox"/> Bacterial meningitis	<input type="checkbox"/> Toxoplasmosis (from cat litter)
<input type="checkbox"/> Sepsis	<input type="checkbox"/> Chemotherapeutic drugs (cisplatin)
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Loop diuretics (furosemide, lasix)
<input type="checkbox"/> Herpes simplex virus	<input type="checkbox"/> Carbon monoxide (CO)
<input type="checkbox"/> Aminoglycoides antibiotics:	
<input type="radio"/> Amikacin	<input type="radio"/> Paromomycin
<input type="radio"/> Arbekacin	<input type="radio"/> Rhodostreptomycin
<input type="radio"/> Gentamicin	<input type="radio"/> Streptomycin
<input type="radio"/> Kanamycin	<input type="radio"/> Tobramycin
<input type="radio"/> Neomycin	<input type="radio"/> Apramycin
<input type="radio"/> Netilmicin	

- Radiation
- Lead

### Birth History

Birth weight: \_\_\_\_\_ Weeks premature/late: \_\_\_\_\_

Were there any delivery complications? yes                      no

If yes, please describe: \_\_\_\_\_

Has your baby received any of the following since birth?

- Placement on an Extra Corporeal Membrane Oxygenation (ECMO) machine
- A stay in the Neonatal Intensive Care Unit (NICU) longer than five days
- Placement on an assisted ventilation machine
- Light treatment for hyperbilirubinemia (jaundice)
- Loop diuretics (for poor kidney function)
- Gentamycin, tobramycin, or any other aminoglycoside antibiotics for infection(s)

### Medical History

- High fever
- Seizure disorder/convulsions
- Past/present medications: \_\_\_\_\_
- Hospitalizations: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Medical conditions: \_\_\_\_\_

### Developmental & Social History

Does your baby startle/respond to loud sounds (eye blink, cry, head turn)? yes                      no

Is there a history of hearing loss with any siblings or cousins in your family? yes                      no

List any diagnosed developmental delays:  
\_\_\_\_\_

Describe any behavioral problems your baby may have:  
\_\_\_\_\_

### Ear History:

Has your baby ever had an ear infection? yes                      no

If yes, how many? \_\_\_\_\_

When was the most recent ear infection? \_\_\_\_\_

Has your baby ever been treated with antibiotics for an ear infection? yes                      no

Is your baby currently on antibiotics for treatment of an ear infection? yes                      no

Has your baby ever received pressure equalization (PE) tubes? yes                      no

Does your baby have frequent colds or congestion? yes                      no

### Additional Information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Providing Information