

DuPage Medical Group – Audiology Department

NEWBORN CASE HISTORY

Child's Name: _____ D.O.B.: _____

Referring Physician: _____ Birth Hospital: _____

Mother's Full Name: _____ Mother's Maiden Name: _____

Birth weight: _____

1. Were there any complications during either birth or pregnancy? Yes No

If yes, describe: _____

2. If known, what were your newborn's APGAR scores?

1 minute: _____ 5 minutes: _____ Not known _____

2. Was your newborn born prematurely? Yes No

If yes, how many weeks? _____

3. Did your newborn pass a hearing screening in either ear in the hospital? Yes No

If yes, which ear? RIGHT LEFT BOTH

4. Do you have any overall concerns regarding your newborn's hearing? Yes No

If yes, please describe: _____

4. Has your newborn taken any medications since birth? Yes No

If yes, what? _____ Reason: _____

5. Are there any genetic disorders diagnosed in your newborn or family? Yes No

If yes, describe: _____

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

- | | |
|---|--|
| <input type="checkbox"/> Family history of childhood hearing loss | <input type="checkbox"/> Hyperbilirubinemia/Jaundice |
| <input type="checkbox"/> Congenital infections | <input type="checkbox"/> Exchange transfusion |
| <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Ventilator used in hospital |
| <input type="checkbox"/> CMV | How long? _____ |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Asphyxia |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Unusual head/neck features | <input type="checkbox"/> Congenital diaphragmatic hernia |

→ _____
Signature of person completing history

Audiologist

→ _____
Relationship to newborn Date

Date