LAKESIDE AUDIOLOGY
Hearing Solutions for All

Newborn Audiology History

Patient Name: _____ **Date of Birth:** _____

Pediatrician: _____

Do you have any concerns about your child's hearing? Yes ☐ No ☐
If yes, please describe concerns:

_____

_____

Do any of your child's relatives have hearing problems? Yes ☐ No ☐
If yes, please describe who and what age it was identified:

_____

_____

PRE-NATAL HISTORY:

Was your child born full term? Yes ☐ No ☐ **How Many Weeks:** _____ **Birthweight:** _____

At which hospital did you deliver? _____

Did any of the following conditions occur during their pregnancy? ***Check all that apply.***

☐ CMV	☐ Substance/Alcohol abuse	☐ Infections
☐ Lack of Oxygen	☐ Communicable Diseases	☐ Other: _____

Did your child require a NICU stay? Yes ☐ No ☐

If yes, how long?:

_____

_____

Did any of these conditions occur during their labor & delivery or hospital stay? ***Check all that apply.***

☐ Cesarean	☐ Congenital defects	☐ Medication given to child
☐ Neonatal Care in NICU	☐ Jaundice	☐ Ventilator
☐ Low APGAR score	☐ Received blood transfusion	☐ Lack of Oxygen

Did your child pass their Newborn Hearing Screening? Yes ☐ No ☐

Any other health concerns we should be aware of? Yes ☐ No ☐

If yes, please describe:

_____

_____

IN-OFFICE USE ONLY:

	SRT / SAT	.5	1	2	4
R					
L					
BC					

	R	L
ECV		
Adm		
daPa		
Reflex		