INDIANA UNIVERSITY

Hearing Clinic
Indiana University Health Sciences Building
2631 E. Discovery Parkway
Bloomington, IN 47408

Newborn Case History

Date: _____ Person Completing questionnaire: _____

Child's Name: _____ Age: _____ Birth date: ____-____-____

Sex assigned at birth: □ M □ F

Address: _____Apt#: _____ City:_____

State: _____ Zip: _____

Parent/Guardian:

Name:_____

Address:_____

_____

Occupation: _____

Work: (___)_____

Home: (___)_____

Cell: (___)_____

Email address: _____

Parent/ Guardian:

Name: _____

Address: _____

_____

Occupation: _____

Work: (___)_____

Home: (___)_____

Cell: (___)_____

Email address: _____

Are languages other than English (including Sign Language) used at home? □ Yes □ No

What languages? _____

Are there any religious or cultural beliefs/practices that should be considered in the child's care? □ Yes □ No

Please explain: _____

Are you concerned about you or your family's level of anxiety and/or coping abilities? □ Yes □ No

Referral Source Information

Name: _____ Relationship to child: _____

Reason for referral: _____

_____

_____

Hearing History and Concerns

Did the child pass the newborn hearing screening? **□ Yes** **□ No**

If no, which ear did not pass? **□ Right** **□ Left** **□ Both**

Hospital where the child was born: _____

Has the child ever had a hearing evaluation? □ Yes □ No When?_____

Where was the evaluation performed? _____

By whom?_____

Results: _____

Yes	**No**	
□	□	Do you feel the child hears well?
□	□	Has the child ever had an ear infection? Which ear? □ Left □ Right □ Both First Occurrence: _____ Last Occurrence: _____ Frequency: _____
□	□	Does the child currently have or ever had draining ears (pus, blood, etc.)?
□	□	Does the child hear the same from day to day?
□	□	Does the child respond to vibrations caused by loud sounds (door slam, truck driving by, airplane, radio in the car, stereo vibration, etc.)?

Adoption/Foster Information

Is the child in adoptive or foster care? □ Yes □ No

Date of adoption/ foster care placement: _____

Birth country of child: _____ Child's placement prior to adoption: _____

Prenatal (pregnancy), Birth, and Development

Biologic mother's age when child was born:_____ Biologic father's age when child was born:_____

Length of pregnancy in weeks: _____

Prenatal:

Yes	**No**	
□	□	Did the biologic mother experience bleeding during pregnancy?
□	□	Did the biologic mother have measles during pregnancy?
□	□	Did the biologic mother have high blood pressure during pregnancy?
□	□	Did the biologic mother experience leaking of the membranes during pregnancy?
□	□	Were there complications during this pregnancy (anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, etc.)? Please describe the complication(s) and treatment(s):_____
□	□	Were prescription/non-prescription drugs (including alcohol) taken during the pregnancy? If so, please list: _____

Birth

Yes	No	
□	□	Vaginal delivery?
□	□	Breech delivery?
□	□	Caesarean Section delivery?
□	□	Were there birth injuries? Please describe: _____
□	□	Breathing difficulties? (e.g., blue baby, required oxygen, stopped breathing, etc.) Please describe: _____
□	□	Special instruments used during delivery? Please describe: _____
□	□	Was the baby jaundice at birth? Treatment needed? _____
□	□	Rh incompatible?

Birth weight: _____lbs. _____oz. 1 minute Apgar_____ 5 minute Apgar _____

How long was the infant's stay in the hospital following birth? _____ □day(s) □week(s) □month(s)

Were there any complications immediately following birth or during the first two weeks of the infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)? _____

_____

_____

Child's Medical History

Pediatrician/Doctor: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (___)_____

Please check all conditions your child presently has or has had:

□ allergies	□ blood disease	□ convulsions	□ asthma	□ chicken pox
□ crossed eyes	□ dental problems	□ influenza	□ diphtheria	□ measles
□ bronchopulmonary	□ whooping cough	□ encephalitis	□ meningitis	□ stroke
□ croup	□ epilepsy/ seizures	□ cerebral palsy	□ mumps	□ apraxia
□ muscle disorder	□ nerve disorder	□ tracheostomy	□ headaches	□ head injury
□ dysarthria	□ heart problems	□ pneumonia	□ RSV	□ dysplasia
□ polio	□ rheumatic fever	□ failure to thrive	□ high fevers	□ CHARGE
□ CMV	□ HIV	□ feeding or swallowing problems		
□ gastro esophageal reflux		□ traumatic brain injury		

Ear, Nose and Throat

Please check all the conditions that the child currently has or has had:

□ chronic coughs/colds	□ hoarse voice	□ difficulty swallowing	□ tonsilitis
□ tonsillectomy	□ adenoidectomy	□ PE tubes	□ dizziness
□ jaw deformity	□ cleft lip/palate	□ tongue deformity	□ ear deformity
□ excessive wax in ears	□ speech problems		

Please list any medications the child is currently taking: _____

_____

If the child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:

Agency/Specialist	Date	What was done?	Results/Recommendations

Name: _____
Address: _____

_____
Phone: _____

Name: _____
Address: _____

_____
Phone: _____

Home and Family

Please list any biologic family members who have a hearing loss (before the age of 50) including brothers, sisters, mother, father, and extended family such as grandparents and cousins, etc.

Name:	DOB:	Age:	Hearing Concern:	Relation to this child:
•				
•				
•				
•				

Please list everyone who lives with this child:

Name:	Age:	Relationship to this child:
•		
•		
•		
•		
•		

This assessment cannot proceed without the signature of the legal guardian.

Signature of parent/guardian: _____Date: _____

Please bring the completed forms with you to the child's appointment. Thank you!