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540.552.1904

Blacksburg • 830 Davis St, Ste 2
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INFANT AND NEWBORN CASE HISTORY

Today's date: ______________________

Child's Name:____ DOB: ______________________

Age: ________________ Gender: ____________________

Child Lives with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____________________________________

Hearing History	**YES**	**NO**
1. Do you have any concerns about your child's hearing?	☐	☐
If yes, briefly explain: ____		
2. Does anyone in your family have hearing loss (Immediate and extended family) that began before the age of 30?	☐	☐
3. Does your child consistently respond to your voice?	☐	☐
4. Does your child respond to loud noises?	☐	☐
5. Does your child have difficulty localizing sounds?	☐	☐
6. Does your child respond to sounds from other rooms?	☐	☐
7. Has your child's hearing ever been tested?	☐	☐
If **yes**, please list by whom, when and results: ______________________________________		

Pregnancy and Birth History	**YES**	**NO**
1. Was the pregnancy abnormal in any way?	☐	☐
2. Was the delivery abnormal in any way?	☐	☐
3. Was the pregnancy full term?	☐	☐
4. Did the mother have any illness during the pregnancy?	☐	☐
5. Did the mother take any medication during the pregnancy?	☐	☐

6. After birth, did your child have?

	YES	NO
Breathing Difficulties:	☐	☐
Require an incubator:	☐	☐
Any head, neck or ear abnormalities:	☐	☐
Feeding problems:	☐	☐
Surgery:	☐	☐
Any infections requiring medication:	☐	☐
Treatment for jaundice (yellow coloration of the skin):	☐	☐

If **yes** to any of the above, briefly explain: ____

____

____

____

Medical History

1. Do you have any medical concerns about your child? ☐ YES ☐ NO

   If yes, briefly explain: ____

   ____

2. Please check if your child has had any of the following:

Ear infections	☐	Meningitis	☐
Ear surgery	☐	Kidney Problems	☐
Hospitalization	☐	Vision Problems	☐
Head Trauma/injury	☐	Seizures	☐

   Noise exposure (farm equipment/loud music) ☐

3. Other significant medical concerns: ______________________________________

   ____

____ ______________________

Signature of person completing form Date

____

Relationship to patient