# Pee Dee Hearing Center

**Newborn/Infant History Form**

**Child's Name**________________________________________ **Date of Birth**______________ **Today's Date** ______________

**Family History**

Do you or anyone in your family have hearing loss that started when they were a child? _______ If so, who? _________________

Do you or anyone in your family have a history of ear infections or PE tubes? ____ If so, who? ___________________________

Does anyone that lives in your household smoke? _______ Yes _______No

**Pregnancy**

Did any of the following occur during pregnancy? (Check all that apply))

___ Alcohol use
___ Herpes
___ RH Incompatibility
___ Toxemia
___ Communicable disease
___ Maternal Infection
___ Smoking
___ Toxoplasmosis
___ Cytomegalovirus (CMV)
___ Maternal Illness
___ Substance (Drug) abuse
___ Zika Virus
___German measles/Rubella
___ Maternal X-rays
___ STDs (Syphilis, Herpes, etc.)
___ Corona Virus (COVID 19)

**Delivery and after birth**

What type of Delivery did your child have? ________Spontaneous/Vaginal __________Induced _______ Cesarean

Was your child born prematurely? _________ If so, how mature was your child at birth? _______Weeks ______Days

Did your child spend time in the NICU)? _________ If so, how long? ___________________________________________

Did your child receive oxygen after birth? _____________ I f so, how long? ____________________________________

Was your child placed on mechanical ventilation after birth? _________ If so, how long? ___________________________

Did your child have any of the following after birth?

___ Ototoxic Medications
___ Bacterial meningitis
___ Head trauma
___ Pulmonary Hypertension
___ Charge Syndrome
___ Skin tags
___ Cleft Palate/Cleft Lip
___ RH incompatibility
___ Down syndrome
___ Small or absent ears
___ Jaundice
___ Meconium Aspiration Syndrome (MAS)
___ Blue Color
___ Low APGAR Score
___ Low Birth Weight

Were there any complications ( e.g.: surgeries) during pregnancy and/or delivery? __________ If so, please explain below.

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

What were the results of your child's Newborn hearing screening?

_____ Passed both ears. ____ Passed left ear only. ____ Passed Right ear only. ____ Failed both ears