DuPage Medical Group – Audiology Department
NEWBORN CASE HISTORY

Patient Label Here

Child's Name: _____
DOB: _____

Referring Physician: _____
Birth Hospital: _____

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

1. Were there any complications during either birth or pregnancy? Yes No
   If yes, describe: _____

2. What was the infant's birth weight?
   _____lbs _____oz(s)

3. If known, what were your newborn's APGAR scores?
   1 minute: _____ 5 minutes: _____ Not known _____

4. Was your newborn born prematurely? Yes No
   If yes, how many weeks? _____

5. Did your newborn pass a hearing screening in either ear in the hospital? Yes No
   If yes, which ear? RIGHT LEFT BOTH

6. Do you have any overall concerns regarding your newborn's hearing? Yes No
   If yes, please describe: _____

7. Has your newborn taken any medications since birth? Yes No
   If yes, what? _____ Reason: _____

8. 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:

- ○ Family history of childhood hearing loss
- ○ Congenital infections
  - ○ Toxoplasmosis
  - ○ CMV
  - ○ Syphillis
  - ○ Herpes
  - ○ Rubella
- ○ Unusual head/neck features
- ○ Hyperbilirubinemia/Jaundice
- ○ Exchange transfusion
- ○ Ventilator used in hospital
  - How long? _____
- ○ Asphyxia
- ○ Head trauma
- ○ Meningitis
- ○ Congenital diaphragmatic hernia

→ _____ _____
Signature of person completing history Date

→ _____
Relationship to newborn