COLUMBUS SPEECH & HEARING CENTER

We Improve Communication for Life

Infant Case History

Today's Date: _____

Child's Name: _____ Age: _____ Date of Birth: _____

Parent/Guardian: _____ Parent/Guardian: _____

Prenatal History

Please check any of the conditions that occurred during pregnancy:

□ Rh incompatibility
□ CMV
□ Rubella/German measles
□ Communicable diseases
□ Substance abuse
□ Lack of oxygen
□ Infections
□ Medication
□ Alcohol abuse
□ Maternal X-rays/illness
□ Toxemia
□ Venereal disease

Birth History

Age of mother at birth: _____ Length of pregnancy: _____

Child's weight at birth: _____ Birth hospital: _____

Please check any of the conditions that occurred during labor/delivery or hospital stay:

□ Caesarean
□ Medication given to child
□ Jaundice
□ Low APGAR scores
□ Lack of oxygen
□ Congenital defects
□ Oxygen administered to mother/child
□ Medication given to mother
□ Special neonatal care or NICU
□ Ventilator

If you checked any of the conditions above, please describe: _____

_____

Has hearing been screened previously? ☐ Yes ☐ No

If yes, please list the results:

_____

_____

Check any of the following conditions that your baby has experienced:

□ Jaundice	□ Antibiotic treatment	□ Blood incompatibility
□ Seizures	□ Rubella	□ CMV
□ Toxoplasmosis	□ Exposed to drugs/alcohol	□ Blood transfusions
□ Herpes Simplex	□ Ear infection or fluid	□ Other: _____
□ Breathing difficulties	□ Meconium stain or aspiration	_____

Please describe: _____

Hearing History

1. Does your baby startle at loud noises? ☐ Yes ☐ No
2. Does your baby quiet to your voice or to music? ☐ Yes ☐ No
3. Does your baby turn towards sounds? ☐ Yes ☐ No
4. Is there a family history of childhood hearing loss? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

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