COLUMBUS SPEECH & HEARING
EST.1923

AUDIOLOGY INFANT HEARING HISTORY

THE FOLLOWING INFORMATION IS CONFIDENTIAL.

Today's Date: _____ Child's Name: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

PRENATAL AND BIRTH HISTORY

1. Were there any complications during your pregnancy or delivery? ☐ YES ☐ NO
   If yes, please explain:

2. Did your baby receive oxygen or ventilation after delivery? ☐ YES ☐ NO
   If yes, please explain:

3. Was your baby cared for in a special care nursery? ☐ YES ☐ NO
   If yes, please explain the circumstances and length of stay:

4. Birth weight: _____ lbs. _____ oz. Age of mother at birth: _____
5. Was your baby born prematurely? ☐ YES ☐ NO
   If yes, how many weeks? _____
6. Please list the birth hospital or other birth location:
   _____
7. Has hearing been screened previously? ☐ YES ☐ NO
   If yes, please explain the circumstances and length of stay:

Check any of the following conditions that your baby experienced:

☐ Jaundice	☐ Breathing difficulties	☐ Meconium stain or aspiration
☐ Seizures	☐ Treated with antibiotics	☐ Blood incompatibility
☐ Toxoplasmosis	☐ Rubella	☐ CMV
☐ Herpes simplex	☐ Exposed to drugs/alcohol	☐ Blood transfusions
☐ Birth defect	☐ Ear infection or fluid	☐ Low APGAR scores

☐ Other: _____

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 currently or did they previously babble using consonants such as “bababa”?	☐ YES	☐ NO
4.	Does your baby turn toward sounds?	☐ YES	☐ NO
5.	Is there a family history of childhood hearing loss?	☐ YES	☐ NO

If yes, please explain:

_____