Hearing Evaluation Services of Buffalo, Inc.
It's Good to Hear

Newborn Hearing Health History

Infant's Name: _____ Date of Birth: _____

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

Siblings (Names & Ages): _____

Info Provided By: _____ Relationship to Child: _____

Pediatrician: _____ _____

Background Information

Do you have concerns regarding your baby's hearing? ☐ yes ☐ no

If so, please describe: _____

Did your baby receive a newborn hearing screening? ☐ yes ☐ no

If so, what were the results? ☐ passed ☐ failed

Has your baby received any other evaluations since birth? ☐ yes ☐ no

If yes, please list: _____

Is there a family history of hearing loss? ☐ yes ☐ no

Does your baby startle/respond to loud sounds (eye blink, cry, head turn)? ☐ yes ☐ no

Pregnancy History and Birth history

Length of Pregnancy (full term, premature, late): _____

Complications during pregnancy: _____

Medications/drugs used during pregnancy: _____

Birth weight: _____ APGAR score (if known): _____

Were there any delivery complications? ☐ yes ☐ no

If yes, please explain: _____

Was your baby in intensive care? ☐ yes ☐ no

Please list any medical conditions your baby has: _____

Please list any medications your baby has received since birth: _____

Other Important Information Not Provided Above

_____

_____

Signature of Person Providing Information: _____ Date: _____