SOUTHSIDE HEARING CENTER

Infant Medical Questionnaire (<1 yr old)

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

- Why was the baby referred for a hearing evaluation?_____

  _____
- Were there any complications during the mother's pregnancy? Yes No

  If yes, please explain:_____
- Was the baby born prematurely? Yes No

  If yes, at how many weeks gestation was (s)he born?_____
- Baby's weight at birth: _____
- Did the baby stay in Neonatal Intensitve Care (NICU) at birth? Yes No

  If yes, for how many days? _____
- Is there a family history of hearing loss and/or deafness? Yes No

HAS THE BABY EXPERIENCED ANY OF THE FOLLOWING?

- intravenous (iv) antibiotics at birth? Yes No
- meningitis Yes No
- jaundice Yes No
- Persistent Fetal Circulations (pulmonary hypertension) Yes No
- hypoxia Yes No
- meconium aspiration Yes No
- respiratory distress syndrome Yes No
- diaphragmatic hernia Yes No
- cytomegalovirus (CMV) Yes No
- mechanical ventilation Yes No

- Does the baby startle to loud sounds? Yes No
- Is the baby soothed by a parent's voice? Yes No
- Has the child been diagnosed with any genetic syndromes or other disabilities? If yes, please list:_____ Yes No

  _____
- Please list any medications the baby is currently on: _____

  _____
- Are there any concerns regarding the baby's ears & hearing? Yes No