Heard It Through The Grapevine Audiology, PC

NEWBORN CASE HISTORY

PATIENT INFORMATION

Child's first name: _____ Last name: _____ Date of Birth: _____

Gender: (check one) ☐M ☐F Weight: ____lb. _____oz. Length: _____ in. Gestational Age ____wks

Place of Birth: (check one) ☐Home ☐Facility Name of Facility: _____

Child's Race: (check one) ☐American Indian/Alaskan Native ☐Asian ☐Black ☐Pacific Islander ☐White

Other: _____ Ethnicity: (check one) ☐Hispanic ☐Not Hispanic ☐Unknown/Prefer not to answer

Maternal Information

Mother's name: _____ Maiden name: _____

Mother's Date of Birth: _____

Mother's Race: (check one) ☐American Indian/Alaskan Native ☐Asian ☐Black ☐Pacific Islander ☐White

Other:_____ Ethnicity: (check one) ☐Hispanic ☐Not Hispanic ☐Unknown/Prefer not to answer

FAMILY HISTORY

Family history of kidney disease ☐YES ☐NO Family history of thyroid problems ☐YES ☐NO

History of progressive blindness ☐YES ☐NO History stillbirths / miscarriages ☐YES ☐NO

Other children with hearing loss ☐YES ☐NO

Family history of hearing loss ☐YES ☐NO

If yes, who? _____ Age loss identified: _____

Mother worked outside home during pregnancy ☐YES ☐NO

If yes, where/what type of work? _____

Father worked outside home during pregnancy ☐YES ☐NO

If yes, where/what type of work? _____

MATERNAL FACTORS

Drugs taken during pregnancy (including antibiotics) ☐YES ☐NO

If yes, specify: _____

Exposure to chemicals during pregnancy ☐YES ☐NO

If yes, specify: _____

Exposure to radiation / chemotherapy during pregnancy ☐YES ☐NO

If yes, specify: _____

Amniocentesis performed during pregnancy ☐YES ☐NO

Rh immunoglobulin given; Rh or ABO incompatible ☐YES ☐NO

Illnesses during pregnancy ☐YES ☐NO

If yes, specify: _____

Anemia during pregnancy ☐YES ☐NO

Diabetes during pregnancy ☐YES ☐NO

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Toxemia during pregnancy ☐ YES ☐ NO

Any paternal illnesses during pregnancy ☐ YES ☐ NO

If yes, specify: _____

During pregnancy, was mother exposed to: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ German Measles

During pregnancy, was mother diagnosed with: ☐ Syphyllis ☐ Herpes ☐ Influenza ☐ Cytomegalovirus(CMV) ☐ HIV/AIDS ☐ Toxoplasmosis ☐ COVID-19 ☐ Other: _____

_____

DELIVERY AND LABOR FACTORS

Full-term pregnancy	☐ YES	☐ NO	If no, how many weeks early: _____
Labor was induced	☐ YES	☐ NO	
Labor less than 3 hours	☐ YES	☐ NO	
Labor longer than 24 hours	☐ YES	☐ NO	
Premature membrane rupture	☐ YES	☐ NO	
Bleeding	☐ YES	☐ NO	
Forceps delivery	☐ YES	☐ NO	
Cesarean section (C-section)	☐ YES	☐ NO	
Other unusual events:	☐ YES	☐ NO	If yes, specify: _____

NEWBORN FACTORS

Birth weight less than 5 pounds	☐ YES	☐ NO	If yes, specify birth weight: _____
APGAR score low at birth	☐ YES	☐ NO	If yes, APGAR score if known: _____
Placed in intensive care	☐ YES	☐ NO	If yes, specify how long: _____
Breathing problems at birth	☐ YES	☐ NO	
Oxygen given at birth	☐ YES	☐ NO	If yes, specify how long: _____
Bilirubin > 15mg/100ml	☐ YES	☐ NO	
Congenital rubella	☐ YES	☐ NO	
Defects of ear, nose, throat	☐ YES	☐ NO	If yes, specify: _____
Congenital heart disease	☐ YES	☐ NO	
Drugs given (inc. antibiotics)	☐ YES	☐ NO	If yes, specify: _____
Exposure to chemicals	☐ YES	☐ NO	If yes, specify: _____
Paralysis at birth	☐ YES	☐ NO	

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Seizures at birth ☐ YES ☐ NO

Septicemia ☐ YES ☐ NO

Longer than 2-4 day hospital stay ☐ YES ☐ NO If yes, specify how long: _____

I give my consent to release my child's hearing/intervention outcomes and individually identifying information to the Department of State Health Services Texas Early Hearing Detection and Intervention (TEHDI) Program. This information will be shared to coordinate services and provide resources, if needed, for my child and our family. This information will not be shared with any parties not involved in hearing screening follow-up and/or intervention process. I understand that I may revoke my consent in writing at any time:

Signature: _____ Date: _____