

Ball State University
Audiology Clinic
Newborn Case History and Assessment

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____ Gender M F

Birth Center _____ Referral Source _____

Reason for referral Initial newborn screening Follow-up to failed screening (RT LT)
 Other: _____

Primary Care Physician: _____

BIRTH MOTHER'S INFORMATION (Check if same as on the *Patient Information and Consent Form*)

Mother's Name _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Phone _____ Email _____

CASE HISTORY / RISK FACTORS

- | | |
|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Family History of Permanent Childhood Hearing Loss
Who: _____
Known reason: _____ | <input type="checkbox"/> <input type="checkbox"/> Mechanical Ventilation
<input type="checkbox"/> <input type="checkbox"/> Extracorporeal Membrane Oxygenation (ECMO)
<input type="checkbox"/> <input type="checkbox"/> Cytomegalovirus (CMV)
<input type="checkbox"/> <input type="checkbox"/> In utero Infection
<input type="checkbox"/> <input type="checkbox"/> Craniofacial Anomalies
<input type="checkbox"/> <input type="checkbox"/> Rubella
<input type="checkbox"/> <input type="checkbox"/> Hyperbilirubinemia requiring exchange or Transfusion
<input type="checkbox"/> <input type="checkbox"/> Herpes |
| <input type="checkbox"/> <input type="checkbox"/> Parental Concerns
Please specify: _____ | <input type="checkbox"/> <input type="checkbox"/> Syphilis
<input type="checkbox"/> <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> <input type="checkbox"/> Special Care / NICU (greater than 5 days)
How long: _____
Reason: _____ | <input type="checkbox"/> <input type="checkbox"/> Bacterial Meningitis
<input type="checkbox"/> <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Ototoxic Medications
Name: _____ | |
| <input type="checkbox"/> <input type="checkbox"/> Genetic Syndromes Associated with Hearing Loss:
If yes, name of syndrome: _____ | |

INFORMATION REVIEWED BY:

Audiologist _____ Graduate Clinician _____ Test Date _____

Ball State University Speech and Audiology Clinic – Family Medical History Form

Patient: _____ Date: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: () _____ Other Phone: () _____ Email: _____

Primary Care Physician: _____ City: _____

Maternal Ethnicity of Patient: _____ Paternal Ethnicity of Patient: _____

Person Completing this Form (if not patient): _____ Relation to patient: _____

Reason for Appointment: _____

Please indicate if the patient or any relatives (including at least 3 generations) currently experience or have experienced the listed symptoms or conditions. Please provide additional information if possible and note which relative (e.g., maternal grandmother) when applicable. Information on family health can be useful in understanding potential causes for hearing, speech or language difficulties or other health issues. While some symptoms (e.g., miscarriages or fainting spells) may seem irrelevant, certain combinations of symptoms may signal an underlying condition that is related to the patient’s primary concern.

Otologic and Hearing problems:

Relationship/Comments:

- | Patient | Relative | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss Present at Birth, Childhood, or Young Adulthood _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss, Any Age of Onset _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vertigo/Dizziness/Balance problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Vision Problems:

- | Patient | Relative | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Premature and/or Progressive, Significant Vision Loss _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Blindness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tunnel Vision _____ |

Learning Disabilities/Developmental Delays:

- | Patient | Relative | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Cognitive Function Impairment (Mental Retardation) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech/Language Delay _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Motor Delay _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Disability of Unknown Cause _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Autistic Spectrum Disorders _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Neurological or Cardiovascular Concerns:

- | Patient | Relative | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Defect _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat _____ |

- | Patient | Relative | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death (unexplained) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | SIDS _____ |

Musculoskeletal

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual Stature _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Craniofacial or Oral Abnormalities _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Palate/Lip _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Anomalies _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Broken Bones _____ |

Kidney

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Malformation _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine _____ |

Pigmentation

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heterochromia (eyes of different color or a multi-colored eye) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hair (early graying, white patches) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vitiligo _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Café au Lait Spots _____ |

Reproductive/Pregnancy Concerns:

- | Patient | Relative | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Stillbirth _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriage _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Early Menopause _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Consanguinity (interfamily relationship) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Infertility _____ |

Endocrine:

- | Patient | Relative | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disorder (enlarged thyroid - goiter) _____ |

Genetic Disorders & Syndromes:

- | Patient | Relative | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Stickler Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Usher Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Branchio-oto-renal Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pendred Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurofibromatosis type II _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitochondrial Disorders _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alport Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Waardenburg Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Long QT Syndrome/Jervell Lange-Nielsen _____ |

Ball State University Speech and Audiology Clinic – Family Medical History Form

Genetic Disorders & Syndromes *(continued)*:

Relationship/Comments:

Patient	Relative	
<input type="checkbox"/>	<input type="checkbox"/>	Pierre-Robin Sequence _____
<input type="checkbox"/>	<input type="checkbox"/>	Treacher Collins Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Connexin 26 Deafness _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Syndromes or Chromosomal Abnormalities _____

Has a family member ever had an evaluation by a geneticist? yes no

Please make any additional comments in the space provided below.

Medications and Supplements Form
Ball State Audiology Clinic

Name: _____ Date of Birth: _____ Phone Number: _____ Today's Date: _____

Please fill in all medications you take, whether regularly or as needed. Fill in as many categories as possible. If you already have a medication list that includes all of the information below, please feel free to bring that list to the appointment instead. Information on medications can be useful in understanding potential causes for hearing difficulties or other health issues. While some medications or supplements may seem irrelevant, certain combinations of medications and symptoms may relate to your hearing or balance problem(s).

Name of Medications or Supplements	Dosage	How often you take the medication?	Reason for taking	Date Started

Please list allergies (medication or other): _____
