Ball State University
Audiology Clinic
Newborn Case History and Assessment

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____ Gender ❑ M ❑ F

Birthing 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

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

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		
☐	☐	Hearing Loss Present at Birth, Childhood, or Young Adulthood	_____
☐	☐	Hearing Loss, Any Age of Onset	_____
☐	☐	Vertigo/Dizziness/Balance problems	_____
☐	☐	Other	_____

Vision Problems:

Patient	Relative		
☐	☐	Premature and/or Progressive, Significant Vision Loss	_____
☐	☐	Night Blindness	_____
☐	☐	Tunnel Vision	_____

Learning Disabilities/Developmental Delays:

Patient	Relative		
☐	☐	Cognitive Function Impairment (Mental Retardation)	_____
☐	☐	Speech/Language Delay	_____
☐	☐	Motor Delay	_____
☐	☐	Learning Disability of Unknown Cause	_____
☐	☐	Autistic Spectrum Disorders	_____
☐	☐	Other	_____

Neurological or Cardiovascular Concerns:

Patient	Relative		
☐	☐	Seizures	_____
☐	☐	Fainting	_____
☐	☐	Tremors	_____
☐	☐	Heart Defect	_____
☐	☐	Heart Attack	_____
☐	☐	Irregular Heartbeat	_____

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Patient	Relative		
☐	☐	Sudden Death (unexplained)	
☐	☐	SIDS	

Musculoskeletal

☐	☐	Unusual Stature	
☐	☐	Craniofacial or Oral Abnormalities	
☐	☐	Cleft Palate/Lip	
☐	☐	Ear Anomalies	
☐	☐	Arthritis	
☐	☐	Frequent Broken Bones	

Kidney

☐	☐	Kidney Malformation	
☐	☐	Kidney Disease	
☐	☐	Blood in Urine	

Pigmentation

☐	☐	Heterochromia (eyes of different color or a multi-colored eye)	
☐	☐	Hair (early graying, white patches)	
☐	☐	Vitiligo	
☐	☐	Café au Lait Spots	

Reproductive/Pregnancy Concerns:

Patient	Relative		
☐	☐	Stillbirth	
☐	☐	Miscarriage	
☐	☐	Early Menopause	
☐	☐	Consanguinity (interfamily relationship)	
☐	☐	Infertility	

Endocrine:

Patient	Relative		
☐	☐	Diabetes	
☐	☐	Thyroid Disorder (enlarged thyroid - goiter)	

Genetic Disorders & Syndromes:

Patient	Relative		
☐	☐	Stickler Syndrome	
☐	☐	Usher Syndrome	
☐	☐	Branchio-oto-renal Syndrome	
☐	☐	Pendred Syndrome	
☐	☐	Neurofibromatosis type II	
☐	☐	Mitochondrial Disorders	
☐	☐	Alport Syndrome	
☐	☐	Waardenburg Syndrome	
☐	☐	Long QT Syndrome/Jervell Lange-Nielsen	

Genetic Disorders & Syndromes *(continued)*: **Relationship/Comments:**

Patient	Relative		
☐	☐	Pierre-Robin Sequence	
☐	☐	Treacher Collins Syndrome	
☐	☐	Connexin 26 Deafness	
☐	☐	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.

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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): _____
_____
_____