Pediatric Sensorineural Hearing Loss Information Sheet

Ear, Nose and Throat Associates of Springfield

CHILD'S NAME: _____ DATE OF BIRTH: _____

PARENT / GUARDIAN: _____

SIBLINGS AND AGES: _____

WHO REFERRED YOU TO THIS OFFICE? _____

PEDIATRICIAN: _____

REPORTS TO BE SENT TO: _____

MD use / Notes

Pregnancy History:

Full term pregnancy? _____ How many weeks? _____

Were there any maternal infections during the pregnancy? _____

Maternal history of (circle):

diabetes hypothyroidism CMV rubella

syphilis herpes simplex HIV toxoplasmosis

Were alcohol, tobacco or drugs used during the pregnancy? _____

Any exposure to Lasix or gentamicin during the pregnancy? _____

Birth History:

Vaginal or C-section delivery? _____

Complications during delivery (explain)? _____

APGAR scores: _____

Birth weight: _____

Intensive care unit stay? _____ How long? _____

Need for mechanical ventilation? _____ How long? _____

Neonatal jaundice (yellow skin)? _____ Bilirubin level: _____

Was a hearing screen done? _____ Results: _____

Medical History:

History of:	yes	no		yes	no
meningitis	____	____	mumps	____	____
head trauma	____	____	measles	____	____
hypothyroidism	____	____	seizures	____	____
visual loss	____	____			

Any major illnesses requiring hospitalization? _____

History of ear infections (circle): none few occasional frequent severe

History of ear tubes? _____ How many sets? _____

Family History:

Are there any other immediate family members with hearing loss (siblings, parents, grandparents)? _____

Any other relatives with hearing loss? _____