

Family Health History

Name (last, first, MI) _____ DOB _____ MRN# _____

AKA _____ Guardian Name(s) _____ Translator Y N

PCP _____ Reporter Name(s) _____ Language _____

Pass Inpatient Pass Outpatient

NHSP Results _____ Screening Provider(s) _____

Refer Inpatient Refer Outpatient

History	Indicators	Additional Clinician Notes
Pregnancy	Length Medications Infections Drug/Alcohol Use Complications Birth Weight	
NICU	<input type="checkbox"/> Stay > 5 Days <input type="checkbox"/> Assisted ventilation <input type="checkbox"/> Ototoxic Meds <input type="checkbox"/> ECMO <input type="checkbox"/> Loop diurectics <input type="checkbox"/> Hyperbilirubemia requiring lights or transfusion <input type="checkbox"/> Surgery <input type="checkbox"/> Other	
Family History	Blood relative(s) with permanent childhood hearing loss:	
Craniofacial	<input type="checkbox"/> Microtia <input type="checkbox"/> Atresia <input type="checkbox"/> Ear tags/pits <input type="checkbox"/> Cleft palate <input type="checkbox"/> Temporal Bone	
Postnatal infections	Culture Positive <input type="checkbox"/> Bacterial meningitis <input type="checkbox"/> Viral meningitis	
Syndromes Neurology disorders	<input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Ushers <input type="checkbox"/> Waardenburg <input type="checkbox"/> Alport <input type="checkbox"/> Pendred <input type="checkbox"/> Jervell Lange-Nielson <input type="checkbox"/> Hunter <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Friederich ataxia <input type="checkbox"/> Other	
Postnatal trauma	<input type="checkbox"/> Head trauma requiring hospitalization <input type="checkbox"/> Skull/Temporal Bone fracture <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Other	
Caregiver Concern/Observation	Does the baby: <input type="checkbox"/> Startle at loud sounds <input type="checkbox"/> Respond to sound at any level Concern of: <input type="checkbox"/> Speech delay <input type="checkbox"/> Language delay <input type="checkbox"/> Developmental delay Note caregiver description of response to sound:	

Have referrals been made to or received from:

- PCP Otolaymngology Genetics Speech/Language Pathologist Early Intervention/Teacher of the Deaf
 Other Audiologist Cochlear Implant Center Other Professionals

Additional relevant information: