Infant Hearing Questionnaire

Patient Name: _____ DOB: _____

Circle "Yes" or "No" for the following questions:

Did you have any complications during birth or delivery? YES NO
If yes, please explain: _____

Did you have any complications during pregnancy? YES NO
If yes, please explain: _____

Did your infant have to have any surgery at birth? YES NO
If yes, please explain: _____

Was your infant in the neonatal intensive care unit (NICU)? YES NO
If yes, for how long? _____

Did your infant have a Newborn Hearing Screening? YES NO
If yes, at which facility and with which doctor(s)? _____

If they had the Newborn Hearing Screening, did they pass? YES NO
If they failed, which ear? _____

Does your infant get startled when they hear loud sounds? YES NO

Does your infant have any visible anomalies of their ears, face, or body? YES NO
If yes, where? _____

Have they been admitted to the hospital since being discharged at birth? YES NO
If yes, please explain. _____

Has your child had a high fever since leaving the hospital? YES NO

Has your child had genetic testing? YES NO

Were you ill during birth or pregnancy? YES NO

Were you told you had any infection(s) during pregnancy? YES NO

Is there anyone with a hearing loss in your family? YES NO
If yes, who? _____

Did their hearing loss occur at birth or childhood? _____

Circle the risk factors your child was born with, if any:
Hyperbilirubinemia/kernicterus Hypoxia Intraventricular hemorrhage None

Does anyone in your family have any genetic disorders, impairments, or syndromes?
(e.g., Waardenburg syndrome, Usher syndrome, Alport syndrome, Turner syndrome) _____

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