Medical Record #: ____________________

Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

Audiology Department
(551) 996-5327

INFANT HEARING QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: ____

Date of Birth: ____________________ Date(s) of Evaluation: ____________________

______________________________ ______________________________
Signature of Patient/Parent/Guardian *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Provider	
Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

DEMOGRAPHIC INFORMATION

Baby's First, Middle, Last Name____________________________________ Date of Birth _________

Address _________________________ City _____________ Zip ________ State ____ County ____

Phone Number: ________________________________ Primary Language: __________________

Parent/Guardian (A) Full Name: ____
First *Last* *(Maiden)*

Address ____________________________________ City _____________ State ____ Zip _______

Date of Birth: _________________ Race: ________________ Ethnicity: ____________________

Please Check: Biological □ Step □ Foster □ Adoptive □ Other □___________________

Parent/Guardian (B) Full Name: ____
First *Last* *(Maiden)*

Address ____________________________________ City _____________ State ____ Zip _______

Date of Birth: _________________ Race: ________________ Ethnicity: ____________________

Please Check: Biological □ Step □ Foster □ Adoptive □ Other □___________________

Pediatrician Name/Group Practice Name: ____

Phone Number: _____________________________ Fax Number: ___________________________

Address: _________________________________ City/State: ___________________ Zip: ______

BIRTH HISTORY

At which hospital was your baby born? ________________ What was your baby's birth weight? _____

Was your baby transferred to another hospital? Where? _____________________________________

Was your baby born premature? _____ If yes, how many weeks? ____ Single □ Twin □ Multiple □

Did your baby receive a newborn hearing screening? ______ If yes, what were the results? _________

Were there any complications during pregnancy or birth? _____________________________________

If yes, please describe: ____

Was your baby cared for in the NICU/special care nursery? _____ If yes, for how many days? _______

Did your baby receive oxygen (nasal cannula) or mechanical ventilation? _______ For how long? ____

Did your baby receive antibiotics? ____ If yes, what type? ________________ For how long? _______

Does your baby startle to loud sounds? _____ Does your baby quiet to your voice or to music? ______

Is there family history of childhood hearing loss? ______ If yes, please explain: __________________

Check any of the following conditions that your baby experienced:

- □ Jaundice
- □ Seizures
- □ Toxoplasmosis
- □ Herpes Simplex
- □ Birth defect: ___________
- □ Breathing difficulties
- □ Blood incompatibility
- □ CMV
- □ Rubella
- □ Blood transfusion
- □ Ear infection/fluid
- □ Exposed to drugs/alcohol
- □ Meconium stain or aspiration
- □ Other: ______________