Newborn Questionnaire

Child's Name: Last _____ First _____ MI ____

Date of Birth: ___/___/___ Gender: Male ___ Female ___

Mother's Name: Last _____ First _____ MI ____

Mother's Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Work Phone: _____

Email Address:_____

Birth Hospital: _____

Pediatrician: _____

Name of Physician/Person Who Referred You if Different From Above:
_____

Did your infant have a hearing test at birth? Yes / No Results: _____

Was your infant full term? Yes / No If No, how many weeks early: _____

Birth Weight: _____ Complications at birth? _____

Any medical conditions / syndromes? _____

Did your infant require extended hospital / NICU stay? _____

Did your infant require any surgeries? _____

Any family history of hearing loss? _____