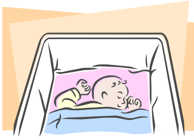
UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Hearing Clinic
(813) 974-8804
(813) 974-0822 - FAX



NEWBORN CASE HISTORY FORM FOR AUDIOLOGY

Date form completed: _________________________ File # ______________________________ (office staff)

IDENTIFYING AND BACKGROUND INFORMATION

Child's Name: ____
Last First Middle

Ethnicity (optional): ☐ African Amer. ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native Amer. ☐ Other _______

Date of Birth: ______________ Age: ________ Gender (optional): ☐ Male ☐ Female

Address: ____
Street City State Zip

Father: _____________________________________ DOB:____________ Education: _________________________

Address:____ Phone(Home):________________(Cell) __________

Occupation: _______________________Place of employment:______________________Phone: ___________________

Mother: ______________________________________ DOB: ____________ Education: _________________________

Address:____ Phone(Home):________________(Cell) __________

Occupation: _______________________Place of employment:______________________Phone: ___________________

E-Mail: __________________ Parents' current status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Person to contact in case of emergency: _______________________ Relationship: _________________
Phone: _____________

Person completing questionnaire: ______________________________Relationship to patient: ____________

REFERRAL INFORMATION

Referred by: ____
Name Address Zip

Reason you are bringing this child for the evaluation: ____

____

Where did you hear about our services? ____

PRENATAL AND BIRTH HISTORY

Were there any complications during your pregnancy or birth? ☐ Yes ☐ No. If "yes", explain: ____________________

____

List drugs/medication taken during pregnancy: ____

Birth weight: ______lbs ______oz   Premature birth (less than 37 weeks)? ☐ Yes ☐ No

Length of pregnancy: _______________ Length of labor: _______________ Delivery was by ☐caesarian ☐ breech

Where was your baby born? ____

Check all that pertain to your baby:

- ☐ Family history of hearing loss: One or more blood relatives of the baby had permanent hearing loss in early childhood: ☐ parent ☐ grandparent ☐ aunt ☐ uncle ☐ baby's first cousin ☐ brother ☐ sister
  Specify who: ____
- ☐ Mother had rubella (measles), cytomegalovirus (CMV), herpes, toxoplasmosis, or syphilis during pregnancy
- ☐ Baby required a blood transfusion shortly after birth due to hyperbilirubinemia
- ☐ Baby required mechanical ventilation (breathing machine) for 5 or more days after birth
- ☐ Baby was in NICU after birth and required ECMO (forced oxygen into tissues)
- ☐ Baby had an infection after birth such as meningitis, mumps, or measles
- ☐ Baby was hospitalized after birth and required IV antibiotics or chemotherapy
- ☐ Baby experienced head trauma (i.e., a serious fall causing a concussion or skull fracture)
- ☐ Baby has been diagnosed with a particular syndrome or disorder (i.e., Down's Syndrome, cleft palate)
- ☐ Baby has had or currently has an infection or fluid behind the eardrum
- ☐ Baby had Anoxia (blue color) after birth
- ☐ Baby was jaundiced (yellow color) after birth requiring treatment with lights or sunlight
- ☐ Baby had swallowing problems after birth ☐ Baby had difficulty sucking after birth

MEDICAL INFORMATION

Name of child's physician: ____________________________________ Date of last visit: _________________________

Reason for last visit: ____

Please list any medications that the child is currently taking: ____

Overnight stays and/or surgeries? ☐ Yes ☐ No. If "yes", list date and reason: ________________________________

____

HEARING HISTORY

Check all that apply:

☐ The baby startles to loud sounds (throws arms out) ☐ The baby is soothed by parent or caregiver voice

SIBLINGS

List names and ages of siblings: ____

ADDITIONAL NOTES/COMMENTS

____

(813) 974-9844
(813) 974-0822 Fax

Client/Patient Authorization regarding Research Studies, Mode of Communication and Educational Use of Recorded Sessions

Client/Patient's Name:___________________________________

Participation in research projects:
Clients/patients may be asked by researchers in the Department if they would be interested in participating in a research study pertaining to their condition. When contacted, clients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. **Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below.**

Initials_____________

___ Please do NOT contact me with opportunities to participate in research

Electronic communication and transmission of service related information:
Authorization is given to the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders, University of South Florida, 4202 E. Fowler Ave., Tampa, Florida 33620-8150, to communicate with me via **email, telephone (voice/text) and/or fax,** regarding therapy and/or assessment for the above named client. I acknowledge that the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders cannot be responsible for non-secured communication.

Initials_____________

Acknowledgement of the recording of sessions (audio and video):
The University of South Florida Department of Communication Sciences and Disorders operates a clinical facility primarily for the training of future professionals in Speech-Language Pathology, Audiology, and Aural (Re)Habilitation. All clients/patients seen in the clinic for diagnostic and therapeutic services must agree to the recording of sessions. Recordings may be reviewed and used by faculty, staff and students as part of a client/patient's plan of care, as part of a research project and/or to facilitate instructional objectives for students enrolled in the program. Appropriate safeguards related to privacy and confidentiality will be utilized for the use and storage of such recordings and this specific authorization regarding the recordings is attached below and must be signed by each patient.

"I understand the above and hereby release to the University of South Florida Department of Communication Sciences and Disorders, the right to make audio and video recordings or to photograph said person in any and all phases of the educational or remedial process and to put the audio and video recordings or photographs to any legitimate educational or training uses. All recordings, photographs and their reproductions shall remain the property of the Department of Communication Sciences and Disorders of the University of South Florida. It is further agreed that in the event the Department of Communication Sciences and Disorders of the University of South Florida or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said audio and video recordings, photographs, and/or descriptive literature or sound tracks, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Signature:____ Date:__________________
Client/Parent/Guardian

Signature:_____________________________________ Date:________________