ANDERSON-OCONEE
SPEECH & HEARING CLINIC

NEWBORN'S CASE HISTORY FORM

FULL NAME:_____ **DATE:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**____ **ZIP:**_____

HOME PH: (_____) _____ **CELL PH:** (_____) _____ **E-MAIL:**_____

BIRTHDATE:_____ **AGE:**_____ **GENDER: Male / Female RACE: W / B / H /OTHER**

Father:_____ **Mother:**_____

Employed by:_____ **Employed by:**_____

Education:_____ **Education:**_____

Other children in the family and their ages:_____

Other family members with speech or hearing problems:_____

Who referred you to our clinic?_____

Family doctor or pediatrician:_____

Did your child pass the newborn hearing screening at the hospital? Yes / No

Other specialists or agencies that have seen or evaluated your child:_____

_____

BIRTH AND MECICAL HISTORY

Age of mother at pregnancy:_____ **During pregnancy, did mother experience any unusual illness, condition, accident, German measles, etc.?**_____

Length of pregnancy:_____ **Duration of labor:**_____ **Were there any complications during pregnancy, labor, or delivery?**_____

Birth weight:_____ **Instruments used:**_____ **Was baby blue, jaundiced, or have any condition worth noting?**_____

Were any antibiotics given? (gentamicin, neomycin, streptomycin, kanamycin, etc.)_____

Please include any additional information which has not been included that may help in the evaluation and treatment of your child:_____

_____

Parent or guardian signature:_____ **Date:**_____