



PHILIPPINE ACADEMY OF NEUROTOLOGY, OTOLOGY & RELATED SCIENCES

A Study Group of the Philippine Society of Otolaryngology-Head & Neck Surgery

NEWBORN HEARING SCREENING HISTORY FORM

Name of Patient _____ Case No _____
 Date of Birth _____ Sex Male Female
 Mothers Name _____ Contact No _____
 Home Address _____
 Attending Physician _____ Contact No _____

I. Birth History (Please fill in the appropriate space)

Age of Gestation _____ weeks LMP USG
 Maturity Testing (Dubowitz Scoring) _____ weeks
 Birthweight _____ grams SGA AGA LGA
 Type of Delivery : NSD CS Low Forceps
 APGAR Score : (at Birth) _____ (at 5 mins) _____
 Congenital Defects : None Yes
 (Please specify defect/s) _____

II. Prenatal History (Please tick appropriate box)

	YES	NO
Maternal Exposure to Infection		
Maternal History of Infection		
Medical Problem Complicating Pregnancy		
Maternal Drug Intake		
Family History of Hearing Loss		

(If there was a yes answer, please write details in the space provided below.)

III. Neonatal History

	YES	NO
Congenital Infection		
Neurologic Problem		
Intubation for more than 5 days		
ICU for more than 2 days		
Hyperbilirubinemia		
Medications given		
Other medical problems		

(If there was a yes answer, please write details in the space provided below.)

