Stony Brook Medicine

ADULT COCHLEAR IMPLANT HISTORY

Date: _____
Name: _____ DOB: _____
Address_____Town:_____Zip:_____
Phone (h): _____ (w): _____ (c): _____
E-mail:_____ in the event we are unable to reach you by phone
Insurance: _____ referral needed? Y N
Referred by _____
Person completing form □Patient □Spouse □Parent/Guardian □Other-Name_____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
Name	Relationship to patient	Address	phone	fax

I authorize the Department to disclose healthcare information to names above.Valid for one year.
Signature of □ Patient □ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

In order for a complete evaluation to be performed the patient will need to have a recent hearing aid check with the audiologist that dispensed the hearing aids. A print out of the hearing aid performance must be brought to the cochlear implant evaluation.

Please bring all previous hearing tests on the day of your appointment.

1. What is your marital status? _____highest level of education? _____
2. Is English your first language? Yes No If no, what is first language? _____
3. Are you employed? Yes No Occupation? _____

Does your hearing loss have an impact on your performance at work? Explain

_____

4. What is your primary mode of communication?

Oral/ speaking lip reading sign language writing _____

5. Are you a good lip reader? Y N _____
6. Can you communicate on the telephone? Y N _____
7. At what approximate age did your hearing loss begin? _____
8. What was the cause of your hearing loss? _____

COMPLETE OTHER SIDE

Name: _____ DOB: _____

9. Has your hearing become worse over time, or has it stayed the same?_____
10. Do you feel that one ear hears better than the other? Yes No If Yes, specify _____

11. Do you wear hearing aid(s) now? Y N If no, have you tried a hearing aid(s) in the past? Y N
Describe _____

12. If you currently use hearing aids, please fill in as much information as you can:

	Right	Left
Hearing aid model/type	_____	_____
Year purchased	_____	_____
Where was it purchased?	_____	_____

13. If you currently use hearing aids, do you feel you get benefit from them?
_____
_____

14. Do you experience any noise in your ears, such as buzzing or ringing? Y N
If yes, which ear: Right Left Both Explain _____

16. Do you experience any dizziness or off-balance feeling? Y N
If yes, please describe: _____

17. How would you rate your overall health? Poor Fair Good Excellent

Do you have any of the following Y N
____Diabetes ____Autoimmune disease ____Head trauma ____Chronic ear infections
List chronic illnesses: _____

18. Have you had ear surgery? Y N If yes, list dates and procedures: _____
_____
19. List all current medications_____

20. How much do you know about a cochlear implant? _____
_____

22. If it is found that you are a candidate for a cochlear implant, what are your expectations?
_____
_____
_____

23. List living immediate family members Names and Relationships_____
_____

Audiologist Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____
Audiologist signature _____ID# _____ Date/Time:_____