Stony Brook Medicine

COCHLEAR IMPLANT HISTORY FORM
Adolescent Cochlear Implant History

DATE: _____

NAME: _____ DOB: _____

ADDRESS: _____

CITY:_____ ZIP:_____

PHONE (H): _____ (W): _____ (C): _____

E-MAIL _____ in the event we are unable to reach you by phone

PRIMARY INSURANCE: _____ REFERRAL NEEDED? Y N

SECONDARY INSURANCE: _____

MOTHER'S NAME _____ FATHER'S NAME _____

Referred by _____

Person completing form □ Parent/Guardian □ Other-Name/Relationsip_____

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 _____

OVER →_

Name: _____ DOB: _____

DOES OR HAS YOUR CHILD BEEN SEEN BY THE FOLLOWING? IF YES PLEASE PROVIDE THE FOLLOWING INFORMATION. **BRING ALL TEST RESULTS WITH YOU ON THE DAY OF YOUR INTITIAL APPOINTMENT.**

	NAME ADDRESS PHONE
AUDIOLOGIST	_____
SPEECH PATHOLOGIST	_____
EAR, NOSE AND THROAT	_____
AUD VERBAL THERAPIST	_____
TEACHER OF THE DEAF	_____
NEUROLOGIST	_____
PSYCHOLOGIST	_____
PT/OT/OTHER	_____

MEDICAL HISTORY

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

_____Seizures _____ Meningitis _____ Encephalitis
_____Persistent sore throat _____ Nasal allergies _____Tonsillitis
_____Sinusitis _____ Other childhood Illnesses

CURRENT MEDICATIONS: _____

HOSPITALIZATIONS SINCE BIRTH: _____

HEAD TRAUMA WITH CONCUSSION OR SKULL FRACTURE: _____

DOES YOUR CHILD HAVE ANY CHRONIC CONDITIONS/SYNDROMES? _____

SPEECH/LANGUAGE BACKGROUND

What is your child's primary mode of communication?_____

Secondary mode if applicable _____

List all languages spoken in the home in order of use _____

What is your child's preferred language? _____

Does your child communicate easily with others? _____

HEARING HISTORY

Age hearing loss first suspected _____

Age hearing loss identified _____

Was your child born with hearing loss? _____

What is the cause? _____

What degree was the hearing loss at initial diagnosis? _____

Name: _____ DOB: _____

Has the hearing loss become worse over time? _____

List the facilities where your child's hearing has been tested _____

Describe your child's hearing loss as explained to you by other professionals_____

Age hearing aids fit _____

Does your child currently wear hearing aids? Y N If so, circle ear: Right Left Both

How many hours a day? _____

When were the current hearing aids purchased? _____ Where? _____

Hearing aid brand/model _____

Does your child have a history of ear infections? _____

Describe in your own words your child's hearing difficulties _____

_____

_____

Is your child familiar with cochlear implants? Yes No Please explain: _____

Has your child expressed interest in cochlear implantation? _____

DOES YOUR CHILD?

	Unaided	**Aided**
Awaken to loud sound	_____	_____
Respond to speech	_____	_____
Respond to his/her name	_____	_____
Hear on the telephone	_____	_____
Discriminate male vs. female voice	_____	_____
Enjoy music or singing	_____	_____

EDUCATION/SCHOOL

SCHOOL NAME/ADDRESS/PHONE _____

TEACHER'S NAME _____

NUMBER OF CHILDREN IN CLASSROOM _____

IS IT A SPECIAL NEEDS CLASS? _____

WHAT IS THE PRIMARY MODE OF COMMUNICATION FOR LEARNING? _____

DOES THE TEACHER USE AN FM? IF SO, TYPE _____

LIST THE CLASSES IN WHICH YOUR CHILD IS MAINSTREAMED WITH HEARING CHILDREN_____

_____

LIST THERAPIES YOUR CHILD RECEIVES AND FREQUENCY? _____

_____

OVER →

Name: _____ DOB: _____

LIST ANY PREVIOUS SCHOOLS ATTENDED, DATES OF ATTENDANCE AND COMMUNICATION MODE USED _____

DOES YOUR CHILD READ? Y N WHAT IS HIS/HER READING LEVEL?_____

AREAS OF ACADEMIC DIFFICULTY _____

EXTRACURRICULAR ACTIVITIES (sports, clubs, etc)_____

_____

FAMILY/SOCIAL HISTORY

DOES YOUR CHILD HAVE ANY RELATIVES WHO HAVE EXPERIENCED ANY OF THE FOLLOWING CONDITIONS AS CHILDREN? IF YES EXPLAIN & INCLUDE THE RELATIONSHIP TO THE CHILD.

Hearing loss	Y	N	_____
Auditory Processing	Y	N	_____
Ear Infections	Y	N	_____
Trouble speaking	Y	N	_____
Learning difficulties	Y	N	_____

List child's siblings and ages _____

Who lives at home? _____

Marital status of parents _____

AUDIOLOGIST COMMENTS (FOR OFFICE USE ONLY):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Audiologist signature _____ID# _____ Date/Time:_____