Stony Brook Medicine

ADULT COCHLEAR IMPLANT HISTORY

Date: _____

Name: _____ DOB: _____

Phone: _____ E-mail: _____

Name and relationship of person completing the form: _____

Provider, outside of Stony Brook, that originally referred you to Stony Brook Audiology or ENT for a cochlear implant evaluation (name and address):

_____

_____

Can results be sent to this provider? Y N Initial Here: _____

Hearing Loss

When was your hearing loss first noticed? _____
When was your hearing loss first diagnosed? _____
Was your hearing loss sudden or gradual? _____
Has your hearing loss worsened over time? Please provide a complete description below.

_____

_____

Is one ear worse than the other? _____
When and where was your last hearing test performed?
Date: _____ Name and address of provider: _____

_____

Do you have any of the following? Please provide a complete description below.

Tinnitus (ringing, buzzing, or any noises in the ear): Y N
If yes, it is necessary to complete the tinnitus questionnaire attached.
Dizziness: Y N _____
Ear Pain: Y N _____
Ear Drainage: Y N _____
Ear Fullness: Y N _____
Family History of Hearing Loss: Y N _____
Ear Surgery: Y N _____
Noise Exposure Y N _____

Name: _____

Hearing Aids

Do you currently use hearing aids? Y N

Have you ever worn hearing aids? Y N

At what age did you first begin wearing hearing aids? _____

Have you worn hearing aids consistently since that time? If not, please explain: _____

_____

If you currently use hearing aids, when do they help? _____

_____

When and where did you purchase your most recent set of hearing aids?

Date: _____ Audiologist Name and Address: _____

_____

Can we send results to the above provider? Y N _____ initials

When was the last time the hearing aids were programmed?

Date: _____ Audiologist Name and Address: _____

_____

If your hearing aids have not been programmed in the last 6 months, please contact your audiologist to do so prior to returning these forms. We will be requesting this information from your audiologist and your cochlear implant evaluation cannot be completed without it.

Communication

How do you communicate? Circle one or more.

Verbally (Speaking) Lipreading Sign Language

What is your primary language? _____

Is your speech affected by the hearing loss? _____

If you get a cochlear implant, are you interested in speech therapy? _____

Describe how you hear in the situations below:

Television: _____

Telephone: _____

Social Situations: _____

Work: _____

Other: _____