

Adult Cochlear Implant Case History

Date _____ Referred by _____

I. General Information

First Name _____ Middle Initial _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Occupation _____ Employed By _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Birth Date _____ Age _____ Gender _____ Martial Status _____

Email: _____

Emergency Contact Person _____ Phone _____ Relation _____

II. Associated Professionals

Physician's Name _____ Phone Number _____

Address _____

Otologist/ENT's Name _____ Phone Number _____

Address _____

Audiologist's Name _____ Phone Number _____

Address _____

Other Professional _____ Phone Number _____

Address _____

III. Statement of Problem

At what age was your hearing loss first diagnosed? _____

Do you know what caused your hearing loss? YES NO If so, what? _____

Which is your better ear? Right Left Same

Is there a family history of hearing loss? YES NO If so, please describe _____

IV. Amplification History

Have you ever worn hearing aids? Right Left Both Ears

When did you : Start wearing aids: _____ Stop wearing aids: _____

Manufacturer and Model of current hearing aids _____

On average, how many hours do you wear your hearing aids each day? _____

Do you feel that you benefit from your hearing aids? _____

Do you use any assistive listening devices? (TTY, FM System, closed captioning, etc.) Please specify _____

V. Communication Information

Do you communicate verbally? Yes No

Please circle any of the following ways you use to communicate with others:

ASL Sign Language Cued Speech Gestures Speak Other _____

*Do you need a professional interpreter for your appointments? Yes No

VI. Cochlear Implant Information

If you are found to be a candidate for a cochlear implant, what are your expectations? _____

Have you ever met someone who has a cochlear implant/s? _____

VII. Cochlear Implant History (Complete the following information if you have a cochlear implant but did NOT receive your cochlear implant through Premiere Speech and Hearing and/or University of Penn.)

Date of surgery _____ Activation date _____

Cochlear Implant Model _____ Sound Processor Model _____

Have you ever an explanted implant? Yes No If so, please describe _____

Rehabilitation services provided by the cochlear implant program _____

Other information _____

VII. Health History

Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route

Have you had any of the following? Please check all that apply.

☐	Ear pain	☐	Trauma (head/ear)	☐	Arthritis
☐	Ear drainage	☐	Meningitis	☐	Diabetes
☐	Ear ringing, buzzing (tinnitus)	☐	Cancer	☐	Stroke
☐	Ear popping	☐	Epilepsy or Seizures	☐	Heart Problems
☐	Ear infections	☐	Alzheimer's or Dementia	☐	Hypertension
☐	Ear Surgery	☐	Genetic Disorders	☐	Loud Noise Exposure
☐	Dizziness or unsteadiness	☐	Craniofacial Anomalies	☐	Other:

List any operations with date of occurrence: _____

Other chronic illnesses: _____

Any drug or other allergies: _____

VIII. Release of Information

I authorize the release of any information that may be necessary for my cochlear implant work-up from the above mentioned professionals to Premiere Speech and Hearing.

Patient Signature

Date

Witness Signature

Date

Website: www.premierespeechhearing.com
Facebook: Premiere Speech and Hearing