Medical Record #: ____________________

Audiology Department
(551) 996-5327

COCHLEAR IMPLANT QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: ____

Date of Birth: ____________________ Date(s) of Evaluation: ____________________

______________________________ ______________________________
Signature of Patient/Parent/Guardian *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

Patient Name: ______________________________
Medical Record #: ____________________

Today's Date: ____________ Name of Person Completing Form: ______________________
Relationship to Patient: ______________________________

PATIENT INFORMATION

Patient's First, Middle, Last Name: ____
Date of Birth: ___________________ Age: ___________ Gender: ______________________
Address: ____
City: ______________________________ State: _____ Zip: __________ County: ____________
Primary Language: _______________________ Other Languages: __________________________
Who referred you for this appointment? ____

PRIMARY CARE PHYSICIAN / PEDIATRICIAN INFORMATION

Primary Care Physician/Pediatrician: ____
Phone Number: ______________________________ Fax Number: _______________________________
Address: ____
City: ____ State: _____ Zip: _______________________

CONTACT INFORMATION

Parent/Contact (A) Full Name: ____
First *Last* *(Maiden)*
Date of Birth: ________________ Race: _______________ Ethnicity: _______________________
Please Check: Biological [ ] Foster [ ] Adoptive [ ] Spouse [ ] Other [ ] _________________
Phone Number: ___________________ Email: ____
Address ____ City ____________ State _____ Zip _______

☐ *check here if address is same as patient*

Parent/Contact (B) Full Name: ____
First *Last* *(Maiden)*
Date of Birth: ________________ Race: _______________ Ethnicity: _______________________
Please Check: Biological [ ] Foster [ ] Adoptive [ ] Spouse [ ] Other [ ] _________________
Phone Number: ___________________ Email: ____
Address ____ City ____________ State _____ Zip _______

☐ *check here if address is same as patient*

Patient Name: ________________________________

Medical Record #: ____________________

AUDIOLOGICAL HISTORY

When was the patient's hearing loss first identified? ____________________

When did the patient first receive hearing aids? ____________________

How often does the patient wear their hearing aids? ____________________

Is there a noticeable difference when the patient wears hearing aids? ____________________

When was the patient's most recent audiological evaluation? ______________ Where? __________________

What were the results? ____________________

What mode of communication does the patient use? (speech, sign, both) ____________________

Does the patient receive speech/language services? ______ If so, where? ____________________

How many times a week? ____________ When was the last speech/language evaluation? ________________

Is there a family history of permanent hearing loss? ____________________

Is there a history of middle ear infections/middle ear fluid? ____________________

COCHLEAR IMPLANT CANDIDATES

List any related medical history (e.g. meningitis, heart conditions, head injury, etc.) ____________________

____

Has the patient ever had a cochlear implant evaluation? ____________________

Why are you interested in a cochlear implant this time? ____________________

____

What are the expectations for a cochlear implant? ____________________

____

COCHLEAR IMPLANT USERS

When and where was the patient implanted? ________________________ Name of Surgeon: ______________

Which ear is implanted? RIGHT LEFT BOTH

What was the patient's last MAPping? ______________________________ Where? ____________________

What device/company does the patient use? ____________________

FOR PEDIATRIC PATIENTS

Child's Place of Birth: ____ Birth Weight: __________________

Were there any complications during pregnancy or birth? ____________________

Was your child cared for in the NICU/special care nursery? Why? ____________________

Was a Newborn Hearing Screening completed at birth? _________________________ Results: _______

List any developmental delays: ____________________

School: ____ Grade: ___________________

Services received at School: ____________________