BOYS TOWN National Research Hospital

Form No. 253 5/2020

Cochlear Implant Adult Questionnaire

Date: _____

Person completing this form: _____ **Relationship to patient:** _____

Patient Name: _____ Birthdate: _____ Gender: ○ Male ○ Female

Address: _____

City: _____ State: _____ Zip: _____

☐ Personal Home ☐ Apartment ☐ Assistive Living ☐ Nursing Home ☐ Other: _____

Mailing Address (If different from above): _____

Main Phone: _____ Landline ○ Cell phone ○

Alt. Phone: _____ Landline ○ Cell phone ○

Work Phone: _____ Landline ○ Cell phone ○

E-Mail: _____

What is the best way to contact you during the daytime? *(Please be aware that we are unable to send texts)*

☐ Main Phone ☐ Alt. Phone ☐ Work Phone ☐ E-mail

Employed: ☐ Full-time ☐ Part-Time ☐ Retired ☐ Not Employed Currently

Occupation: _____

Place of Employment: _____

Primary Language/ Language(s) spoken at home: _____

Do you need an interpreter for your appointment? ○ Yes ○ No

If yes, please specify type: ☐ Spanish ☐ ASL ☐ Signed English ☐ Other: _____

What is the highest level of education you have completed?

☐ Some high school, no diploma ☐ High school diploma or GED ☐ Some college level courses

☐ Associates Degree ☐ Bachelor's degree ☐ Master's or doctorate degree

Hearing Related Medical History

1. When did you first notice your hearing loss? _____

2. a. Was the onset of your hearing loss: ○ Slow/Progressive ○ Sudden

   b. If sudden, please describe the onset in detail: _____

3. When were you officially diagnosed with hearing loss? _____

4. Has your hearing loss changed over time? ○ Yes ○ No

5. a. If yes, please describe the change(s) ☐ Slow/Progressive ☐ Sudden decreases ☐ Fluctuating

   b. Please provide details: _____

6. Did you lose your hearing in both ears at the same time? ○ Yes ○ No

7. Is there one ear that is your "better hearing ear?" ○ Yes ○ No If yes, which ear: ○ Right ○ Left

8. When and where was your last hearing test: _____

9. Do you know the cause of your hearing loss? ○ Yes ○ No If yes, please check all that apply:

   ☐ Otosclerosis ☐ Noise Related ☐ Meningitis (at age): _____

   ☐ Drugs/Medication (Specify): _____ ☐ Syndrome (Specify): _____

   ☐ Genetic/Hereditary (Specify): _____

   ☐ Other (Specify): _____

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Hearing Related Medical History-*Continued*

10. a. Is there any hearing loss within your immediate or extended family? ○ Yes ○ No
    b. If so, for whom, what was the diagnosis, and at what age?

11. a. Have you had frequent exposure to any of the following? (Check all that apply)
    ☐ Gunfire ☐ Loud machinery ☐ Loud music ☐ Loud engines (motorcycles, planes, tractors, etc.)
    b. If so, please provide details:

    c. If yes, did you wear ear protection during this exposure?

12. a. Did you serve in the military? ○ Yes ○ No
    b. If so, what service and how many years?

13. Please indicate if you have ever experienced any of the following problems or symptoms listed below:

Symptom/Problem	Which Ear(s)		Please provide details including the frequency and severity:
☐ Ringing in the ears	R ☐	L ☐	
☐ Ear infections	R ☐	L ☐	
☐ Ear fullness	R ☐	L ☐	
☐ Ear injury	R ☐	L ☐	
☐ Ear surgery	R ☐	L ☐	
☐ Drainage	R ☐	L ☐	
☐ Dizziness			
☐ Imbalance			

14. a. Have you had any medical imaging of your ears or head? ○ Yes ○ No
    b. If yes, when and where? _____
    c. If yes, what type of imaging? ☐ X-ray ☐ CT scan ☐ MRI ☐ I don't know

Amplification History

15. Please describe below what kind(s) of amplification devices you have tried or currently use? (*Please check all that apply.*)

Device	When was the device fit?	Ear(s)		Device Brand/Model
☐ Hearing Aid		R ☐	L ☐	
☐ CROS[1] or BiCROS[2]		R ☐	L ☐	
☐ BCD[3]/AOD[4] (e.g., BAHA[5])		R ☐	L ☐	
☐ Personal FM System		R ☐	L ☐	
☐ Never fit with amplification				

[1]Contralateral Routing of Signal (CROS), [2]Bilateral CROS (BiCROS), [3]Bone Connection Device, [4] Auditory Osseointegrated Device (AOD), [5]Bone Anchored Hearing Aid

16. What device(s) do you currently use? _____
17. Where and from whom were the device(s) dispensed?

18. How many hours a day do you wear the device(s)?
19. If you do not wear your device(s) fulltime, what prevents full-time use?

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Communication

20. How do you communicate with others in person? (*Please check all that apply.*)
    - ☐ Spoken Language
    - ☐ American Sign language (ASL)
    - ☐ Signed Exact English (SEE)
    - ☐ Written statements (e.g. white board, notepad)
    - ☐ Other: _____

21. Are you able to understand spoken language via the telephone? ○ Yes ○ No

22. What is your preferred method of distance communication with friends and family?
    - ☐ Spoken calls
    - ☐ Captioned calls
    - ☐ Video communication
    - ☐ Text messages
    - ☐ E-mails

23. a. Have you ever used an FM system to understand speech in noise or at a distance? ○ Yes ○ No
    b. If yes, please describe the FM system and when it was/is used:

24. a. Have you ever used any other form of assistive listening devices? (i.e., amplified telephones, loop systems, etc.) ○ Yes ○ No
    b. If yes, please describe the technology and how it is/was used:

25. a. Have you ever used any type of alerting device for sounds you cannot hear? (i.e., visual door bell, vibrating alarm clock, etc.) ○ Yes ○ No
    b. If yes, please describe the technology and how it is/was used:

Medical History

26. Please list below or provide an attached list of your current medications.

27. Have you ever been treated with the following?
    - ☐ Diuretic/"Water pill"
    - ☐ Intravenous antibiotic
    - ☐ Amino glycoside
    - ☐ Long-term aspirin therapy

28. a. Are you allergic to anything? ○ Yes ○ No
    b. If yes, please list and describe.

29. a. Do you use a cane, walker, or wheelchair to get around? ○ Yes ○ No
    b. If yes, how often do you use the assistive device?

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Medical History Continued

Please list any surgeries, hospitalizations, accidents, or injuries you have had below. Please include specifics (i.e., **where** you were hospitalized/treated, **when**, and for **what reason**).

30. Ear Surgeries:

31. Surgeries:

32. Hospitalizations:

33. Accidents/Injuries:

34. a. Have you ever been diagnosed with or treated for any of the following? *(If the answer is no, please leave blank.)*

	Yes	Not Sure		Yes	Not Sure		Yes	Not Sure
ADD OR ADHD	☐	☐	Diabetes (Type:_____)	☐	☐	Meningitis (Bacterial)	☐	☐
Allergies/Asthma	☐	☐	Depression	☐	☐	Mental health concerns	☐	☐
Balance problems	☐	☐	Head injury/Concussion	☐	☐	Metabolic problems	☐	☐
Arthritis	☐	☐	Genetic syndromes	☐	☐	Muscle problems	☐	☐
Asperger/Autism Spectrum Disorder	☐	☐	Demyelinating disease *(e.g. Multiple Sclerosis)*	☐	☐	Neurodegenerative disease *(e.g. ALS, Parkinson's, Alzheimer's, or Huntington's)*	☐	☐
Blood disorder	☐	☐	Heart problems	☐	☐	Radiation/Chemotherapy	☐	☐
Cancer	☐	☐	Hypertension	☐	☐	Seizures/Epilepsy	☐	☐
Cerebral palsy	☐	☐	Joint or bone problems	☐	☐	Sinus infections	☐	☐
Cleft palate &/or lip	☐	☐	Kidney/Urinary problems	☐	☐	Skeletal malformation	☐	☐
Cognitive Delays	☐	☐	Learning disability	☐	☐	Thyroid problems	☐	☐
Craniofacial surgery	☐	☐	Memory loss	☐	☐	Stroke	☐	☐
Other: _____								

b. Please explain any "yes" or "not sure" answers:

c. If you have any other formal diagnosis not listed above, please describe below:

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Vision

35. When was your last vision test? _____

36. Do you have vision loss? ○ Yes ○ No (If yes, check all that apply below.)

- ☐ Nearsightedness ("myopia" can see clearly up close but blurry in the distance)
- ☐ Farsightedness ("hyperopia" can see clearly in the distance but blurry up close)
- ☐ Presbyopia (need glasses to read smaller print)
- ☐ Cataract ☐ Diabetic Retinopathy ☐ Optic Nerve Hypoplasia ☐ Retinitis Pigmentosa
- ☐ Coloboma ☐ Macular Degeneration ☐ Neurological/Cortical Vision Impairment ☐ Glaucoma
- ☐ Not Sure ☐ Other _____

37. a. Do you wear glasses? ○ Yes ○ No

b. If yes, is your vision corrected to normal? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

Understanding Your Needs and Concerns

Your responses to the questions below will help us to get to know you and better understand your concerns.

38. With whom do you spend most of your time?

39. What affect has your hearing loss had on you and those closest to you?

40. If you are currently employed, what challenges do you face at work because of your hearing loss?

41. What activities are you involved in within or outside of your home?

42. How has hearing loss affected these activities?

43. On a rating scale of 1 to 10, how interested are you in receiving a cochlear implant and why?

44. What do you hope to gain with a cochlear implant?

45. What are your greatest fears regarding cochlear implantation?

46. What questions would you like answered during your cochlear implant candidacy evaluation?

47. Is there any other information of which you feel the team should be aware?

48. a. Were you referred for this assessment? ○ Yes ○ No

b. If yes, by whom? _____

Patient Name: _____

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49. Who are the most important people in your life?

Name	Age	Gender	Lives **with** you?	Has Hearing Loss?	Relationship
		M ◯ F ◯	Y ◯ N ◯	Y ◯ N ◯	
		M ◯ F ◯	Y ◯ N ◯	Y ◯ N ◯	
		M ◯ F ◯	Y ◯ N ◯	Y ◯ N ◯	
		M ◯ F ◯	Y ◯ N ◯	Y ◯ N ◯	
		M ◯ F ◯	Y ◯ N ◯	Y ◯ N ◯	

Listening and Communication Questionnaire

The following questions inquire about your ability and experiences hearing and listening in different situations. For each question, put a check in one of the five categories that best describes your experiences.

One-on-One Conversations in Quiet	Never	Rarely	Sometimes	Often	Always
1. I can follow a conversation with one other person in a quiet environment when I can see the talker's lips and face.	☐	☐	☐	☐	☐
2. I can follow a conversation with one other person in a quiet environment without looking at the talker.	☐	☐	☐	☐	☐
One-on-One Conversations in Noise	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
3. I can follow a conversation with one other person in a noisy environment when I can see the talker's lips and face.	☐	☐	☐	☐	☐
4. I can follow a conversation with one other person in a noisy environment without looking at the talker.	☐	☐	☐	☐	☐
Group Conversations in Quiet Environments	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5. I can follow a group conversation in a quiet environment when I can see their lips and faces.	☐	☐	☐	☐	☐
6. I can follow a group conversation in a quiet environment without looking at the talkers.	☐	☐	☐	☐	☐
Group Conversations in Noise	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
7. I can follow a group conversation in a noisy environment when I can see their lips and faces.	☐	☐	☐	☐	☐
8. I can follow a group conversation in a noisy environment without looking at the talkers.	☐	☐	☐	☐	☐
Other Situations	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9. I can understand a person talking more than 10 feet away.	☐	☐	☐	☐	☐
10. I can follow television programs without reading the closed captions.	☐	☐	☐	☐	☐
11. I can follow conversations over the telephone without using captions.	☐	☐	☐	☐	☐
12. I feel confident talking with strangers despite my hearing loss.	☐	☐	☐	☐	☐
13. I enjoy social gatherings despite my hearing loss.	☐	☐	☐	☐	☐
14. I feel safe going outside my home or going to new places.	☐	☐	☐	☐	☐
15. I feel close to my family and friends despite my hearing loss.	☐	☐	☐	☐	☐
16. I rely on someone to help me communicate with others.	☐	☐	☐	☐	☐
17. I spend a lot of energy concentrating when listening to spoken communication, and I feel tired at the end of the day due to the listening effort I put forth.	☐	☐	☐	☐	☐

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Expectations Questionnaire

50. Please mark the following statements as **true** or **false**

- ○ T ○ F All cochlear implant recipients are able to understand speech at initial activation.
- ○ T ○ F Speech will sound natural to all cochlear implant recipients.
- ○ T ○ F Cochlear implant recipients no longer need to speechread/lipread.
- ○ T ○ F Cochlear implant recipients can understand speech in background noise easily.
- ○ T ○ F Television programs are easy to understand for cochlear implant recipients.
- ○ T ○ F Cochlear implant recipients report that music sounds natural.
- ○ T ○ F All cochlear implant recipients can determine the location of a sound without visual cues.
- ○ T ○ F All cochlear implant recipients can communicate over the telephone.
- ○ T ○ F Insurance will cover all equipment costs.
- ○ T ○ F Cochlear implant recipients no longer have hearing loss.
- ○ T ○ F All cochlear implant recipients eventually have the same hearing abilities.
- ○ T ○ F Cochlear implant recipients will lose their natural hearing in the ear implanted after surgery.
- ○ T ○ F Recipient's outcomes are dependent on how much hearing loss they had prior to implantation.
- ○ T ○ F Recipient's outcomes are dependent on if they used a hearing aid prior to implantation.
- ○ T ○ F Recipient's outcomes are dependent on how much they use their devices.

Additional Information

51. Please let us know if you would like more information or are interested in any of the following opportunities listed below:

- ☐ Receive information about caption phones
- ☐ Receive information about FM systems or other assistive listening devices
- ☐ Receive information about alerting devices for people with hearing loss
- ☐ Meet or speak with a recipient of a cochlear implant

Medical Records and Insurance Information

52. a. Primary Care Physician: _____

b. Location: _____

c. Primary Insurance: _____ Secondary Insurance: _____

d. Other: _____

53. Please complete and return the following items along with this form:

- ☐ Copy of audiogram
- ☐ Copy of your insurance cards
- ☐ Signed medical release form
- ☐ Immunization records

Send the most recent copies of the items listed above to:

Mailing Address:	Fax Number:	Email:
Cochlear Implant Patient Services Coordinator BTNRH/CCDLL 555 N. 30th Street Omaha NE 68131	531-355-5028	CITeam@boystown.org

If you have any questions, call the Cochlear Implant Patient Services Coordinator at 531-355-5698

For Office Use Only:

Reviewing Clinician's Name: _____ Date Reviewed: _____ Date Reviewed w/Team: _____

Clinician's Signature: _____