Providence HEALTH CARE

BC ADULT COCHLEAR IMPLANT PROGRAM
PATIENT QUESTIONNAIRE

Phone: 604-806-9616

Completing this questionnaire is an important part of your Cochlear Implant (CI) candidacy assessment. Your answers provide us with detailed information about your past and present hearing abilities and how you are managing them. Please mail the completed questionnaire in the enclosed self-addressed envelope. Please make sure the information is as accurate and thorough as possible. Feel free to add any additional comments where available. Your efforts are very helpful!

PATIENT INFORMATION

Today's date: _____
Month / Day / Year

Person completing this questionnaire: ☐ Self ☐ Other: _____
Name / Relationship

Patient Name: _____
Last Name First Name

Date of Birth: _____ **Care Card #:** _____
Month / Day / Year

Address: _____
Apartment / House / Street City Province Postal Code

Phone: _____ **TTY:** _____

Fax: _____ **Email:** _____

List anyone who lives at the same address: _____
Name Relationship

_____
Name Relationship

If you need assistance for appointments, please list a preferred contact person:

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Language: ☐ English ☐ Sign Language Other: _____

Is an Interpreter is required? ☐ Yes ☐ No

Have you been assessed by the BC Adult Cochlear Implant program before?

☐ Yes - _____ ☐ No
Month / Year

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MEDICAL HISTORY

Family Physician: _____
Name of Physician Address City Postal Code

Ear Specialist(s): _____
Name of Physician Year Seen

_____
Name of Physician Year Seen

How is your general health? ☐ Good ☐ Fair ☐ Poor

List any medical conditions that you are currently being treated for.

_____

_____

List any medical diagnoses that you have been given in the past.

_____

_____

Have you ever been diagnosed with a cognitive, psychological, or psychiatric condition? ☐ Yes ☐ No

If your answer is YES, please explain: _____

_____

_____

Have you ever had an ear infection or drainage from your ears? ☐ Yes ☐ No

If your answer is YES, how many times has it happened? ☐ Once ☐ Few Times ☐ Many Times

If your answer is YES, when was the last infection or drainage?

Right Ear: _____ Month /Year Left Ear: _____ Month /Year

Have you been diagnosed with Otosclerosis? ☐ Unknown ☐ Yes ☐ No

Have you been diagnosed with conductive hearing loss? ☐ Yes ☐ No

If your answer is YES, when were you given the diagnosis?

Right Ear: _____ Month /Year Left Ear: _____ Month /Year

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MEDICAL HISTORY (continued)

Have you ever had any ear surgery? ☐ Yes ☐ No

If your answer is YES, what type of surgery was it? When was the surgery?

Right Ear: _____
Type of Surgery Year

Left Ear: _____
Type of Surgery Year

Did the surgery improve your ability to hear? ☐ Yes ☐ No

Did a head injury ever cause a hearing loss? ☐ Yes ☐ No

If your answer is YES, describe what happened. When did it occur?

Right Ear: _____
Describe the circumstances Year

Left Ear: _____
Describe the circumstances Year

Have you ever suffered from dizziness? ☐ Yes ☐ No

If your answer is YES, describe what it feels like when you were dizzy, including the sensation and how long the dizziness lasted.

_____

_____

Approximate date of the first dizziness spell: _____

Date of the most recent dizziness spell: _____

Have you ever been given any of the following ototoxic medications?

☐ Streptomycin	☐ Aspirin ® (large dosage)	☐ Dihydrostreptomycin
☐ Lasix® (Furosemide)	☐ Coumadin (Warfarin)	☐ Neomycin
☐ Chemotherapy	☐ Tetanus Antitoxin	☐ Kanamycin
☐ Neftilmicin	☐ Quinine	☐ Gentamycin
☐ Heparin	☐ Tobramycin	☐ Chloroquine

☐ Other: _____

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NOISE EXPOSURE HISTORY

Have you ever been exposed to loud noises that may have caused your hearing loss? ☐ Yes ☐ No

If your answer is YES, describe the type of noise you were exposed to and how long was the exposure.

Work Related Noise: _____ (Source of Noise) _____ (Duration of Exposure)

Military Service: _____ (Source of Noise) _____ (Duration of Exposure)

Gunfire/Hunting: _____ (Source of Noise) _____ (Duration of Exposure)

Recreational Noise: _____ (Source of Noise) _____ (Duration of Exposure)

Music/Concerts: _____ (Source of Noise) _____ (Duration of Exposure)

Other: _____ _____ (Source of Noise) _____ (Duration of Exposure)

Did you wear hearing protection? ☐ Occasionally ☐ Yes ☐ No

Are you currently exposed to loud noises? ☐ Yes ☐ No

If your answer is YES, are you currently wearing hearing protection? ☐ Yes ☐ No

If you have been exposed to loud noises, are you receiving Third Party Hearing Benefits? ☐ **Yes** ☐ **No**

If your answer is YES, when did you begin receiving these benefits?

☐ Workers Compensation Board: _____ (Year)

☐ Veterans Affairs Canada: _____ (Year)

☐ Non-Insured Health Benefits: _____ (Year)

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TINNITUS HISTORY

Do you ever hear any noises in your head or ears (tinnitus)? ☐ Yes ☐ No

If your answer is YES, when did you first become aware of the tinnitus?

Right Ear: _____ (Month / Year) Left Ear: _____ (Month / Year)

Describe what the tinnitus sounds like: Right Ear: _____

Left Ear: _____

Is the tinnitus constant or does it fluctuate? ☐ Constant ☐ Fluctuate

In which ear is the noise the worst? ☐ Right ☐ Left

How much does the tinnitus impact your daily life?

☐ No impact ☐ Moderate impact
☐ Mild impact ☐ Severe impact

How much does the tinnitus interfere with your sleep?

☐ No interference ☐ Moderate interference
☐ Mild interference ☐ Severe interference

Do any of the following make your tinnitus worse?

☐ Fatigue ☐ Aspirin ☐ Stress ☐ Anxiety
☐ Alcohol ☐ Caffeine ☐ Loud Noise ☐ Nervousness
☐ Medications: _____ Other: _____

Have you tried anything to help deal with the tinnitus? ☐ Yes ☐ No

If your answer is YES, please describe what you have tried.

_____

_____

_____

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HEARING LOSS HISTORY

When were you or your family first aware of your hearing loss?

Right Ear: _____ (Year) Left Ear: _____ (Year)

Have you ever had a sudden drop in your hearing? ☐ Yes ☐ No

If your answer is YES, describe what happened. When did it occur?

Right Ear: _____ (Describe the Circumstances) (Year)

Left Ear: _____ (Describe the Circumstances) (Year)

Does your hearing fluctuate up and down? ☐ Yes ☐ No

If your answer is YES, describe what happens. When did it begin?

Right Ear: _____ (Describe the Circumstances) (Year)

Left Ear: _____ (Describe the Circumstances) (Year)

What was the cause of your hearing loss?

Right Ear: _____

Left Ear: _____

Has your hearing loss become worse over time?

Right Ear: ☐ Yes ☐ No Left Ear: ☐ Yes ☐ No

When did your hearing become as bad as it is now?

Right Ear: _____ (Year) Left Ear: _____ (Year)

Currently, which is your better hearing ear? ☐ Right Ear ☐ Left Ear

How often do you find it difficult to understand other people's speech?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Please list any family members who also have severe hearing loss.

_____

_____

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AMPLIFICATION HISTORY

Have you ever worn a hearing aid? ☐ Right Ear ☐ Left Ear

When did you first begin to wear hearing aids?

Right Ear: _____ (Year) Left Ear: _____ (Year)

Do you wear hearing aids currently? ☐ Right Ear ☐ Left Ear

Hearing Aid Clinic(s) Visited:

_____
Name of Current Clinic | Name of Audiologist/Dispenser | City

_____
Name of Current Clinic | Name of Audiologist/Dispenser | City

Where did you purchase your current hearing aid(s)?

_____
Clinic Name | Audiologist/Dispenser | City

Do you pay for your own hearing aids? ☐ Yes ☐ No

If your answer is NO, which organization pays for them? _____

When did you purchase your current hearing aids?

Right Ear: _____ (**Month** / Year) Left Ear: _____ (**Month** / Year)

If you are not using a hearing aid, please explain why you are not.

_____

_____

If you are currently not using a hearing aid, how long has it been since you last wore a hearing aid?

Right Ear: _____ (**Month** / Year) Left Ear: _____ (**Month** / Year)

With or without your hearing aid(s), are you able to understand conversations over the phone?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

If your answer was NEVER, how long has it been since you could use the telephone (with or without your hearing aids)?

Right Ear: _____ (**Month** / Year) Left Ear: _____ (**Month** / Year)

Do you use a TTY/VCO phone? ☐ Yes ☐ No

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AMPLIFICATION HISTORY (continued)

With your hearing aid(s), are you able to understand speech when you *ARE NOT* looking at the talker?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

With your hearing aid(s), are you able to understand speech when you *ARE* looking at the talker?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Do other people have difficulty understanding you when you speak?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Without a hearing aid, can you hear any sounds at all?

☐ Some in each ear ☐ Yes, right ear only ☐ Yes, Left ear only ☐ No

If you are currently using a hearing aid, please describe the situations in which it is helpful.

Please be specific: _____

_____

If you are currently using a hearing aid, please describe the situations in which you continue to have difficulties.

Please be specific: _____

_____

With your hearing aid(s), do you enjoy listening to music?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

On the following table, list the hearing aids that you have worn, starting with your most current hearing aids.

Manufacturer	Style	Ear	Dates worn	Hours/day used
		Right		
		Left		
		Right		
		Left		
		Right		
		Left		
		Right		
		Left		

Do you use any Assistive Listening Devices to help you hear? ☐ Yes ☐ No

If your answer is YES, please list which devices you have used: _____

_____

Do you use any Alerting Devices to help you hear and remain safe? ☐ Yes ☐ No

If your answer is YES, please list which devices you have used: _____

_____

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COMMUNICATION TRAINING

Have you received any formal Speech/Lip Reading Training? ☐ Yes ☐ No

If your answer is YES, please indicate where and when you received your training?

Where _____ When _____

Was the training helpful? ☐ Not Helpful ☐ Helpful ☐ Very Helpful

Have you received training in Sign Language? ☐ Yes ☐ No

If your answer is YES, how often do you communicate using Sign Language?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Have you received training in Cued Speech? ☐ Yes ☐ No

If your answer is YES, how often do you communicate using Cued Speech?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Has the severity of your hearing loss caused you to resort to communicate by writing? ☐ Yes ☐ No

If your answer is YES, how often do you communicate by writing?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Have any of your family members ever received training to communicate with people who are hard of hearing?

☐ Yes ☐ No

Are your friends and family mostly: ☐ Deaf/Signers ☐ Hard of Hearing ☐ Hearing

Who are the people you communicate with on a daily basis?

☐ Spouse ☐ Children ☐ Grandchildren ☐ Friends ☐ Siblings

Others: _____

Have you ever received any Speech Therapy? ☐ Yes ☐ No

If your answer is YES, where did you receive the speech therapy?

Name of Clinic _____ Name of Speech Pathologist _____ City _____

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FINANCIAL INFORMATION

There are short-term and long-term costs associated with the candidacy assessment, surgery and follow-up (e.g. time off work, parking, gas/transportation, accommodation for out of town patients), and CI maintenance. We ask about your general financial situation so support can be offered to you if possible.

What are your sources of income?

☐ Employment ☐ Pension/CPP (Retirement) ☐ CPP (Disability) ☐ Provincial Disability Benefits (PWD)
☐ No fixed income Other: _____

Who manages your finances? ☐ Self ☐ Other: _____
Name / Relationship

Are you currently in any financial distress? Please indicate on the scale:

I ---------- I
No financial distress Extreme financial distress

EMPLOYMENT INFORMATION

Are you presently employed? ☐ Yes ☐ No

If your answer is YES, what kind of work do you currently do? _____

_____

If your answer is NO, is it because of your hearing loss? ☐ Yes ☐ No

How noisy is your workplace? I ---------- I
Not Noisy Extremely Noisy

How often do you need to communicate at work?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Does your job depend on your ability to hear? ☐ Yes ☐ No

Please describe how you communicate at work? _____

_____

_____

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TELL US HOW ARE YOU MANAGING YOUR HEARING LOSS

Who provides you with the most help with your hearing loss?

Name: _____ Relationship to you: _____

What kind of help do you receive from others?

Please check all that apply, and indicate who provides the support

TYPE OF SUPPORT	Family	Friends	Employer	Social/Mental Health/Community Worker/Other
☐ Emotional	☐	☐	☐	☐
☐ Financial	☐	☐	☐	☐
☐ Transportation	☐	☐	☐	☐
☐ Personal care (e.g. dressing/bathing)	☐	☐	☐	☐
☐ Daily household chores (e.g. cooking, cleaning)	☐	☐	☐	☐
☐ Communication with others	☐	☐	☐	☐

Are you currently having challenges managing your day-to-day living? ☐ Yes ☐ No

If your answer is YES, please describe: _____

_____

_____

Hearing loss can have an emotional impact on the person, and it is normal to be frustrated, anxious, sad, and angry at times.

Do you find that it is becoming difficult to manage these feelings? ☐ Yes ☐ No

Do you want a Cochlear Implant? ☐ Yes ☐ No

Do you have any concerns about getting a Cochlear Implant? ☐ Yes ☐ No

If your answer is YES, please describe these concerns: _____

_____

_____

_____

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TELL US HOW ARE YOU MANAGING YOUR HEARING LOSS (continued)

Does anyone in your support network have any concerns about you getting a Cochlear Implant?

☐ Yes ☐ No

If your answer is YES, please describe: _____

_____

_____

Please mark with an "X" below where you would rate your overall hearing ability to be when wearing your hearing aids:

0% ---------- **100%**
Totally Deaf Normal Hearing

Please mark with an "X" below where you would rate the percentage of hearing ability you expect to have when using a cochlear implant?

0% ---------- **100%**
Totally Deaf Normal Hearing

Please describe what you want the cochlear implant to do for you, should you be a candidate and receive it?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____