Providence Health Care

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BC ADULT COCHLEAR IMPLANT PROGRAM PATIENT QUESTIONNAIRE

DOCUMENT TYPE

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. Make sure the information is as accurate and thorough as possible and feel free to add any comments where available, your efforts are very helpful.

PATIENT INFORMATION

Today's date: (dd/mmm//yyyy) ____________________

Person completing this questionnaire ☐ Patient ☐ Other: ____
(Name/Relationship)

Legal name: ____
Last Name First Name

Preferred name: ____

Preferred pronoun: ☐ He ☐ She ☐ They ☐ Other______________________________

Date of Birth: (dd/mmm/yyyy) ____________________ **PHN:** (personal health number) ____________________

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

Phone: ____________________ **TTY:**____________________ **Email:** ____________________

List anyone who lives with you: ____
Name Relationship

____
Name Relationship

____
Name Relationship

Language: ☐ English ☐ Sign language: (please indicate what type) ____________________ ☐ Other:____________________

Is an interpreter required? ☐ No ☐ Yes

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

☐ No ☐ Yes Date: (dd/mmm/yyyy) ______________________________

If you need assistance during appointments, or wish to include someone in our communication regarding your appointments, assessments, and/or follow up care, provide that person's contact information below.

Name: ______________________________ Relationship:______________________________

Phone: ______________________________ Email: ______________________________

MEDICAL HISTORY

Primary Care Provider: ______________________________
Name

Ear Specialist: ______________________________
Name Year Seen

____
Name Year Seen

How would you rate your general health? ☐ Good ☐ Fair ☐ Poor

List any medical conditions you are currently being treated for:

____

____

List any medical diagnoses you have been given in the past:

____

____

How would you rate your cognitive or mental health? ☐ Good ☐ Fair ☐ Poor
If your answer is poor, please tell us more:

____

____

Have you ever had an ear infection or drainage from your ears? ☐ No ☐ Yes
If you answered Yes, how many times has it happened: ☐ Once ☐ Few times ☐ Many times
If you answered Yes, when was the last infection or drainage?

Right Ear: ____________________ Left Ear: ____________________
Month / Year Month / Year

Have you been diagnosed with otosclerosis? ☐ No ☐ Yes ☐ Unknown
Have you been diagnosed with conductive hearing loss? ☐ No ☐ Yes
If you answered Yes, when were you given the diagnosis?

Right Ear: ____________________ Left Ear: ____________________
Month / Year Month / Year

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MEDICAL HISTORY continued

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

If your answer is Yes, what type of ear surgery did you have and when was it?

Right Ear: ______________________________

Type of Surgery Year

Left Ear: ______________________________

Type of Surgery Year

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

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

If your answer is Yes, describe what happened and when it occured

Right Ear: ______________________________

Describe the circumstances Year

Left Ear: ______________________________

Describe the circumstances Year

DIZZINESS HISTORY

Have you ever suffered from dizziness/vertigo/imbalance? ☐ No ☐ Yes

If your answer is Yes, please make sure to fill out the **CI Dizziness Questionnaire** included in this package to provide a more detailed description of your dizziness, including triggers, onset and resolution of your dizziness.

What was the approximate date of your **first** dizziness spell? ______________________________

What was the date of your **most recent** dizziness spell? ______________________________

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

☐ Streptomycin ☐ Aspirin ® (greater than 12 325 mg tablets per day) ☐ Dihydrostreptomycin

☐ Lasix® (Furosemide) ☐ Coumadin (Warfarin) ☐ Neomycin

☐ Chemotherapy ☐ Tetanus Antitoxin ☐ Kanamycin

☐ Neftilmicin ☐ Quinine ☐ Gentamycin

☐ Heparin ☐ Tobramycin ☐ Chloroquine

☐ Other (specify medication, dosage and frequency)______________________________

HEARING LOSS HISTORY

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

Right Ear: ______________________ Left Ear: ______________________
Year Year

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

If your answer is Yes, describe what happened and when it occurred.

Right Ear: ____
Describe the circumstances Year

Left Ear: ____
Describe the circumstances Year

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

If your answer is Yes, describe what happens and when it began.

Right Ear: ____
Describe the Circumstances Year

Left Ear: ____
Describe the Circumstances Year

Do you know the cause of your hearing loss?

Right Ear: ____

Left Ear: ____

Has your hearing loss become worse over time?

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

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

Right Ear: ______________________ Left Ear: ______________________
Year 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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NOISE EXPOSURE HISTORY

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

If your answer is Yes, describe the type of noise you were exposed to and how long the exposure lasted:

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? ☐ No ☐ Yes ☐ Inconsistently

Are you exposed to loud noises in your current day-to-day life (e.g. use power tools or lawnmowers, attend concerts)?

☐ No ☐ Yes

If your answer is Yes, do you wear hearing protection? ☐ No ☐ Yes ☐ Inconsistently

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

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

☐ WorkSafe BC: ______________________________
Year

☐ Veterans Affairs Canada: ______________________________
Year

☐ Non-Insured Health Benefits: ______________________________
Year

TINNITUS HISTORY

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

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 ☐ Fluctuates

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

How much does the tinnitus impact your daily life?

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

How much does the tinnitus interfere with your sleep?

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

Do any of the following make your tinnitus worse?

☐ Fatigue ☐ Aspirin ☐ Stress ☐ Anxiety

☐ Alcohol ☐ Caffeine ☐ Loud Noise ☐ Nervousness

☐ Medications: ________________

☐ Other: ________________

How loud do you perceive your tinnitus? Mark with an “X” below where you would rate the loudness of your tinnitus over the last week:

0 -- 100
No Tinnitus Very loud

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

If your answer is Yes, please describe what you have tried: ________________

____

____

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AMPLIFICATION HISTORY

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

When did you first start wearing a hearing aid?

Right Ear: ______________________ Left Ear: ______________________
Year Year

Do you currently wear hearing aids? ☐ 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 Name of Audiologist/Dispenser City

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

If your answer is No, which organization pays for them? ______________________

When did you purchase your current hearing aids?

Right Ear: ______________________ Left Ear: ______________________
Month/Year Month/Year

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

____

If you used to wear hearing aids, but no longer wear them, how long has it been since you last wore them?

Right Ear: ______________________ Left Ear: ______________________
Month/Year 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: ______________________ Left Ear: ______________________

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

AMPLIFICATION HISTORY Continued

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

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

☐ 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?

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

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

____

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

____

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? ☐ No ☐ Yes
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? ☐ No ☐ Yes
If your answer is Yes, please list which devices you have used: ______________________________

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COMMUNICATION TRAINING

Have you participated in any formal speech/lip reading training? ☐ No ☐ Yes

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 participated in training in Sign Language? ☐ No ☐ Yes

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

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

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? ☐ No ☐ Yes

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

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

☐ No ☐ Yes

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 participated in any speech therapy? ☐ No ☐ Yes

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

____

Name of clinic Name of Speech Pathologist City

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? ☐ No ☐ Yes

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? ☐ No ☐ Yes

Mark with an “X” below how noisy your workplace is:

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? ☐ No ☐ Yes

Describe how you most often 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	☐	☐	☐	☐
☐ Activities of daily living (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? ☐ No ☐ Yes

If your answer is Yes, please describe. ______________________

____

____

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

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

Do you want a Cochlear Implant? ☐ No ☐ Yes ☐ Unsure

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

If your answer is Yes, please describe these concerns: ______________________

____

____

____

Does anyone in your support network have any concerns about you getting a Cochlear Implant? ☐ No ☐ Yes

If your answer is Yes, please describe: ______________________

____

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MANAGING HEARING LOSS continued

If you wear hearing aids regularly, mark with an “X” where you would rate your hearing ability to be while wearing your hearing aids:

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

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

Describe what you want the cochlear implant to do for you, should you be a candidate to receive it: