BOYS TOWN National Research Hospital

Form No. 253 10/2017

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 day time? *(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): _____

Patient Name: _____ Cochlear Implant Adult Questionnaire

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? _____

Patient Name: _____ **Cochlear Implant Adult Questionnaire**

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: _____

Patient Name: _____ Cochlear Implant Adult Questionnaire

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 Sclorosis)*			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:

Patient Name: _____ **Cochlear Implant Adult Questionnaire**

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 Reinopathy ☐ Optic Nerve Hypoplasia ☐ Retinitis Pigmentosa

☐ Coloboma ☐ Macular Degeneration ☐ Neurological/Cortical Vision Impairment ☐ Glacoma

☐ 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? _____

44. 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: _____ **Cochlear Implant Adult Questionnaire**

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	

Speech Spatial Qualities (SSQ12)

The following questions inquire about aspects of your ability and experiences hearing and listening in different situations. For each question, put a cross (x), anywhere on the 1-10 rating scale. **Ten** means you would be perfectly able to do or experience what is described and **zero** means you would be unable to do or experience what is described. If a question does not apply to you, mark the not applicable (N/A) box.

Question	*Not at all* — *Perfectly* (0 1 2 3 4 5 6 7 8 9 10)	N/A	SSQ49
You are talking with one other person and there is a TV on in the same room. Without turning the TV down, can you follow what the person you're talking to says?		☐	Speech in noise 1.1
You are listening to someone talking to you, while at the same time trying to follow the news on TV. Can you follow what both people are saying?		☐	Multiple speech streams 1.10
You are in conversation with one person in a room where there are many other people talking. Can you follow what the person you are talking to is saying?		☐	Speech in speech 1.11
You are in a group of about five people in a busy restaurant. You can see everyone else in the group. Can you follow the conversation?		☐	Speech in noise 1.4
You are with a group and the conversation switches from one person to another. Can you easily follow the conversation without missing the start of what each new speaker is saying?		☐	Multiple speech streams 1.12
You are outside. A dog barks loudly. Can you tell immediately where it is, without having to look?		☐	Localization 2.6
Can you tell how far away a bus or a truck is from its sound?		☐	Distance and movement 2.9
Can you tell from the sound whether a bus or truck is coming towards you or going away?		☐	Distance and movement 2.13
When you hear more than one sound at a time, do you have the impression that it seems like a single jumbled sound?		☐	Segregation 3.2
When you listen to music, can you make out which instruments are playing?		☐	Identification of sound 3.7
Do every day sounds that you can hear easily seem clear to you (not blurred)?		☐	Quality & naturalness 3.9
How much do you have to concentrate when listening to someone or something?		☐	Listening effort 3.14

The SSQ12 was developed for use in clinical research and rehabilitation settings to assess the effects of hearing loss across several domains. Reference: Noble W., Jensen N. S., Naylor G., Bhullar N., Akeroyd M. A. (2013). A short form of the speech, spatial and qualities of hearing scale suitable for clinical use: the SSQ12. Int. J. Audiol. 52, 409-412.

Patient Name: _____ Cochlear Implant Adult Questionnaire

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 Manager BTNRH/CCD 555 N. 30th Street Omaha NE 68131	531-355-5028	CIPatientManager@boystown.org

If you have any questions, call the Cochlear Implant Patient Manager at 531-355-5059

For Office Use Only:

Reviewing Physician's Name: Date Reviewed: Date Reviewed w/Team:

Clinicians Signature: _____