Premiere Speech and Hearing
Implantable Hearing Device Program
555 Second Avenue, C-850
Collegeville, PA 19426
(610) 454-1177
(610) 454-0416 (fax)

Adult Cochlear Implant Case History

Date _____ Referred by _____

I. General Information

First Name_____ Middle Initial_____ Last Name_____

Street Address_____

City_____ State _____ Zip Code_____

Occupation_____ Employed By _____

Home Phone_____ Work Phone _____ Mobile Phone_____

Birth Date_____ Age_____ Gender_____ Martial Status_____

Email: _____

Emergency Contact Person_____ Phone_____ Relation_____

II. Associated Professionals

Physician's Name_____ Phone Number_____

Address_____

Otologist/ENT's Name_____ Phone Number_____

Address_____

Audiologist's Name_____ Phone Number_____

Address_____

Other Professional_____ Phone Number _____

Address_____

III. Statement of Problem

At what age was your hearing loss first diagnosed? _____

Do you know what caused your hearing loss? YES NO If so, what? _____

Which is your better ear? Right Left Same

Is there a family history of hearing loss? YES NO If so, please describe_____

IV. Amplification History

Have you ever worn hearing aids? Right Left Both Ears

When did you : Start wearing aids:_____ Stop wearing aids:_____

Manufacturer and Model of current hearing aids_____

On average, how many hours do you wear your hearing aids each day? _____

Do you feel that you benefit from your hearing aids? _____

Do you use any assistive listening devices? (TTY, FM System, closed captioning, etc.) Please specify

_____

V. Communication Information

Do you communicate verbally? Yes No

Please circle any of the following ways you use to communicate with others:

ASL Sign Language Cued Speech Gestures Speak Other _____

*Do you need a professional interpreter for your appointments? Yes No

VI. Cochlear Implant Information

If you are found to be a candidate for a cochlear implant, what are your expectations? _____

_____

Have you ever met someone who has a cochlear implant/s? _____

VII. Cochlear Implant History (Complete the following information if you have a cochlear implant but did NOT receive your cochlear implant through Premiere Speech and Hearing and/or University of Penn.)

Date of surgery_____ Activation date _____

Cochlear Implant Model _____Sound Processor Model_____

Have you ever an explanted implant? Yes No If so, please describe_____

Rehabilitation services provided by the cochlear implant program _____

Other information_____

VII. Health History

Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route

Have you had any of the following? Please check all that apply.

	Ear pain		Trauma (head/ear)		Arthritis
	Ear drainage		Meningitis		Diabetes
	Ear ringing, buzzing (tinnitus)		Cancer		Stroke
	Ear popping		Epilepsy or Seizures		Heart Problems
	Ear infections		Alzheimer's or Dementia		Hypertension
	Ear Surgery		Genetic Disorders		Loud Noise Exposure
	Dizziness or unsteadiness		Craniofacial Anomalies		Other:

List any operations with date of occurrence: _____

_____

_____

Other chronic illnesses: _____

Any drug or other allergies: _____

VIII. **Release of Information**

I authorize the release of any information that may be necessary for my cochlear implant work-up from the above mentioned professionals to Premiere Speech and Hearing.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

***Website*: www.premierespeechhearing.com**
***Facebook*: Premiere Speech and Hearing**