

Henry Ford Health Systems Cochlear Implant Program
Adult Case History Form

I. GENERAL INFORMATION

Name: _____

Address: _____

Phone: _____

Birth date: _____

E-mail address _____

Occupation and Employer: _____

Marital Status: S M W D

Name of spouse or significant other: _____

E-mail address and phone number of significant other: _____

II. HEARING HISTORY

1. When was your hearing loss first diagnosed?(RIGHT) _____ (LEFT) _____

2. Which do you feel is your better hearing ear? **LEFT RIGHT SAME**

3. What is the cause of your hearing loss? _____

4. Please circle which best describes your hearing loss:
Sudden Progressive Stable Since birth

5. Is there a family history of hearing loss? **Yes No Who?** _____

6. Do you have tinnitus (noises in your ear)? **R: Yes No L: Yes No**

7. Do you have dizziness? **Yes No**

8. Can you communicate over the telephone? **Yes No**

III. AMPLIFICATION & COMMUNICATION HISTORY:

1. Do you currently wear hearing aids? **Yes** **No**
Which ear? Left Right Both
Make/Model _____
How long have they been worn? _____

2. How do you prefer to communicate?
ASL Signed English Lip-Reading Cued Speech Oral
Other _____

IV. HEALTH INFORMATION

1. Were there complications at your birth or illness during your infancy? _____
If yes, please describe: _____

2. Are you currently taking any medications? **Yes** **No**
If yes, please list:

3. Have you ever had surgery? **Yes** **No**
If yes, please specify:

4. Have you ever had any of the following illnesses? If so, please list age at time of illness.
Measles _____ Scarlet Fever _____ Meningitis _____

**Please fill out the questionnaire attached. Answer either true or false depending on what you would expect if you were to receive the cochlear implant.