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.