Cochlear Implant Evaluation Intake

Name____ Date ______/_______/________

Statement of Problem

At what age was your hearing loss identified? ____

What was the cause of your hearing loss? ____

Is there a family history of hearing loss? If yes, please describe. _________________________

____

Do you hear better out of one ear? YES NO If yes, which ear? _____________________

Amplification History Do you wear hearing aids? RIGHT EAR LEFT EAR BOTH N/A

If yes, when did you start wearing hearing aids? RIGHT: _________ LEFT: ________

How many hours per day do you wear your hearing aid(s)? ________________________

How old are your current hearing aids? ____

Do you use any assistive listening devices (Caption phone, TTY, FM system, closed captioning)?

____

Preferred communication method(s): ORAL SIGN LANGUAGE TOTAL COMMUNICATION

Health History *Please circle if you have any of the following:*

Tinnitus Epilepsy Seizures Stroke Hypertension (high blood pressure)

Diabetes Cancer Allergies Dizziness Dementia Depression/Anxiety

Other: ____

History of ear infections? ____

History of ear surgery? ____

Has your vision been evaluated? YES NO If yes, when? ____________

Current Medications: ____

____

Hearing Handicap Inventory for Adults

Name: ____

Date: ___________________________________

Instructions: The purpose of the scale is to identify the problems your hearing loss may be causing you each question.

Check: Yes, Sometimes, or No
Do not skip a question if you avoid a situation because of a hearing problem.

		Yes (4)	Sometimes (2)	No (0)
S1	Does a hearing problem cause you to use the phone less often than you would like?			
E2	Does a hearing problem cause you to feel embarrassed when meeting new people?			
S3	Does a hearing problem cause you to avoid groups of people?			
E-4	Does a hearing problem make you irritable?			
E-5	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S-6	Does a hearing problem cause you difficulty when attending a party?			
S-7	Does a hearing problem cause you difficulty hearing/understanding coworkers, clients, or customers?			
E-8	Do you feel handicapped by a hearing problem?			
S-9	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
E-1 0	Does a hearing problem cause you to feel frustrated when talking to coworkers,			

S-1 1	Does a hearing problem cause you difficulty in the movies of theater?			
E-12	Does a hearing problem cause you to be nervous?			
S-13	Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			
E-14	Does a hearing problem cause you to have arguments with family members?			
S-15	Does a hearing problem cause you difficulty when listening to TV or radio?			
S-16	Does a hearing problem cause you to go shopping less often than you would like?			
E-17	Does any problem or difficulty with your hearing upset you at all?			
E-18	Does a hearing problem cause you to want to be by yourself?			
S-19	Does a hearing problem cause you to talk to family members less often than you would like?			
E-20	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S-21	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
E-22	Does a hearing problem cause you to feel depressed?			
S-23	Does a hearing problem cause you to listen to TV or radio less often than you would like?			
E-24	Does a hearing problem cause you to feel uncomfortable when talking to friends?			
E-25	Does a hearing problem cause you to feel left out when you are with a group of people?			

Total # points	/100	Total # of points for SOCIAL	/48	Total # of points for EMOTIONAL	/52

- [ ] 0-16% = No handicap
- [ ] 18-42% = Mild-Moderate Handicap
- [ ] 44%+ = Significant Handicap

Adapted from Newman, C.W., Weinstein, B.E., Jacobson, G.P. and Hug, G.A., Test-retest reliability of the Hearing Handicap Inventory for Adults, Ear Hear., 12, 355-357 (1991)

Cochlear Implant Quality of Life-10 Global

INSTRUCTIONS: Think about your daily life with your cochlear implant (and/or hearing aid, if you also use one). Answer how often each of the following statements applies to your feelings and experiences. Answer how often each statement applies even if you don't use cochlear implants or hearing aids.

	Never	Rarely	Sometimes	Often	Always
1. I am able to have a conversation in a quiet place without asking the other person to repeat themselves					
2. I can hear and understand without looking at the person speaking					
3. I can understand strangers without lip-reading in a noisy place					
4. I feel comfortable being myself					
5. I keep quiet in a conversation to avoid saying the wrong thing					
6. I am able to enjoy listening to the radio and TV					
7. I can hear someone approaching from behind					
8. I am able to follow a conversation with minimal effort					
9. I have to concentrate when having a conversation with strangers when in a noisy place					
10. I avoid socializing with friends, relatives, or neighbors due to my hearing loss					

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