THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Adult Audiology (Patient)
Cochlear Implant Evaluation Form

Date:
Patient Name:
DOB:

Please provide the following information to the best of your ability:

What problem(s) are you here for today?_____

_____

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:
2) For any "Yes" answers, please check the "Current" box if this symptom relates to the reason for your visit today

	Yes	No	Current		Yes	No	Current
Ear pain	☐	☐	☐	Ear drainage	☐	☐	☐
Ear pressure	☐	☐	☐	Tinnitus/Ear noises	☐	☐	☐
Hearing loss	☐	☐	☐	Vertigo (spinning)	☐	☐	☐
Imbalance	☐	☐	☐				

Have you been exposed to significant noise? (Factory work / guns / military) ☐ **Yes** ☐ **No** **Type/Frequency:**_____

Do you have a family history of hearing loss? ☐ **Yes** ☐ **No** **Indicate family member(s):**_____

Have you ever had ear surgery? ☐ **Yes** ☐ **No** **Type/ear:**_____

1. **How old were you when hearing loss was first identified and diagnosed?**

   _____

2. **What caused your hearing loss?**

   _____

3. **Which is your better hearing ear?**

   _____

4. **When did you obtain your first hearing aid(s)?**

   _____

5. **How old are your current hearing aids?**

   _____

6. **Who dispensed your current hearing aids?**

_____

7. **When was your last hearing aid check up or adjustment?**

_____

8. **Can you hear well on the phone? If not, when was the last time you heard well on the phone?**

_____

9. **Which ear do you use on the phone? Has this changed over time?**

_____

10. **Do you enjoy music? If not, when was the last time you were able to enjoy music?**

_____

11. **Do you use other assistive listening devices or alerting devices (for TV, phone, smoke detector, wake up alarm, etc)?**

_____

12. **Do you know anyone who has a cochlear implant?**

_____

Would you like a report including today's test results sent to your physician? Yes ☐ No ☐
If yes, please provide your physician's name and address or fax number below.

_____

_____

_____

REFERRAL SOURCE: OSU ENT PHYSICIAN ☐ FAMILY PHYSICIAN ☐ FRIEND ☐ FAMILY ☐ ADVERTISEMENT ☐

THE OHIO STATE UNIVERSITY HEARING PROFESSIONALS

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