Providence Health Care

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BC ADULT COCHLEAR IMPLANT PROGRAM
BILATERAL SEQUENTIAL
PATIENT QUESTIONNAIRE

DOCUMENT TYPE

Completing this questionnaire is an important part of your Cochlear Implant (CI) candidacy assessment. Your answers provide us with detailed information about your past and present hearing abilities and how you are managing them. Please mail the completed questionnaire in the enclosed, self-addressed envelope. Make sure the information is as accurate and thorough as possible and free to add any additional comments where available, your efforts are very helpful.

PATIENT INFORMATION

Today's date: (dd/mmm/yyyy) _____

Person completing this questionnaire: ☐ Patient ☐ Other:_____
(Name/Relationship)

Legal name: _____
Last Name First Name

Preferred name: _____

Preferred pronoun: ☐ He ☐ She ☐ They ☐ Other:_____

Date of Birth: (dd/mmm/yyyy) _____ **PHN** (personal health number): _____

Address: _____
Apartment/House/Street City Province Postal Code

Phone: _____ **TTY:** _____Email: _____

Language: ☐ English ☐ Sign language: (Please indicate what type) _____ ☐ Other: _____

Is an interpreter is required? ☐ No ☐ Yes

Are you a current patient of our clinic: ☐ No ☐ Yes

If **Yes**, please skip to the next section: **"MEDICAL HISTORY**" If **No,** or if your address has changed, please contact the cochlear implant department at ci@providencehealth.bc.ca or at 604 806 9616.

If you need assistance for appointments, or wish to include someone in our communication regarding your appointments, assessments and/or follow up care, please list a preferred contact person.

Name: _____ Relationship: _____

Phone: _____ Email: _____

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MEDICAL HISTORY

How would you rate your general health? ☐ Good ☐ Fair ☐ Poor

List any other medical conditions or diagnoses you are currently being treated for:

_____

_____

How would you rate your cognitive or mental health? ☐ Good ☐ Fair ☐ Poor

If your answer is poor, please tell us more:

_____

_____

DIZZINESS HISTORY

Have you ever suffered from dizziness/vertigo/imbalance? ☐ No ☐ Yes

If your answer is **No**, go to the next section, **HEARING LOSS HISTORY**.

If your answer is **Yes**, please make sure to fill out the **CI Dizziness Questionnaire,** included in this package to provide a more detailed description of your dizziness including triggers, and onset of your dizziness. If your dizziness has resolved, please also describe the resolution of your dizziness.

What was the approximate date of your **first** dizziness spell? _____

What was the date of your **most recent** dizziness spell? _____

HEARING LOSS HISTORY

Indicate which ear currently has a cochlear implant. ☐ Right ☐ Left

Has your hearing loss become worse over time in your non-implanted ear? ☐ No ☐ Yes

If Yes, please indicate whether the decline was:

☐ Sudden: _____

Describe the circumstances Year

☐ Gradual

When did your hearing become as bad as it is now in your non-implanted ear? _____

Year

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TINNITUS HISTORY

Do you ever hear any noises in your head or ears (tinnitus)? ☐ No ☐ Yes

If your answer is Yes, when did you first become aware of the tinnitus?

Right Ear: _____ Left Ear: _____

Month/Year Month/Year

Describe what the tinnitus sounds like:

Right Ear: _____ Left Ear: _____

Is the tinnitus constant or does it fluctuate? ☐ Constant ☐ Fluctuates

In which ear is the noise the worst? ☐ Right ☐ Left

How much does the tinnitus impact your daily life?

☐ No impact ☐ Mild impact ☐ Moderate impact ☐ Severe impact

How much does the tinnitus interfere with your sleep?

☐ No interference ☐ Mild interference ☐ Moderate interference ☐ Severe interference

Do any of the following make your tinnitus worse?

☐ Fatigue ☐ Aspirin ☐ Stress ☐ Anxiety

☐ Alcohol ☐ Caffeine ☐ Loud Noise ☐ Nervousness

☐ Medications: _____

☐ Other: _____

How loud do you perceive your tinnitus? Mark with an "X" below where you would rate the loudness of your tinnitus over the last week:

0---------- 100

No Tinnitus Very loud

Have you tried anything to help deal with the tinnitus? ☐ No ☐ Yes

If your answer is Yes, please describe what you have tried. _____

_____

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AMPLIFICATION HISTORY

Do you currently wear a hearing aid in your non-implanted ear? ☐ No ☐ Yes

How many hours per day (on average) do you wear your hearing aid? _____

Do you experience a benefit from your current hearing aid? Please explain.

_____

_____

With your hearing aid in are you able to understand conversations over the phone?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

If you are not currently using a hearing aid, how long has it been since you last wore a hearing aid?

Right Ear: _____ Left Ear: _____

Month/Year Month/Year

If you are not using a hearing aid, please explain why you are no (e.g. no benefit perceived, issues with fit, etc.).

_____

_____

COCHLEAR IMPLANT HISTORY

How many hours per day (on average) do you wear your sound processor? _____

_____

Do you experience a benefit from your cochlear implant? Please explain.

_____

_____

_____

Select the areas in which you currently find benefit from wearing your hearing aid with your sound processor.

☐ Improvement in overall sound quality ☐ Enjoyment of music

☐ Sound awareness ☐ No benefit perceived

☐ Other: _____

Describe the situations in which you continue to have difficulties.

Please specify: _____

_____

_____

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FINANCIAL INFORMATION

There are short-term and long-term costs associated with the candidacy assessment, surgery and follow-up (e.g. time off work, parking, gas/transportation, accommodation for out of town patients), and CI maintenance. We ask about your general financial situation so support can be offered to you, if possible.

What are your sources of income?

☐ Employment ☐ Pension/CPP (Retirement) ☐ CPP (Disability)

☐ Provincial Disability Benefits (PWD) ☐ No fixed income

Other: _____

Who manages your finances? ☐ Self ☐ Other: _____

Name/Relationship

Are you currently in any financial distress? Please indicate on the scale:

I ----------I

No financial distress Extreme financial distress

EMPLOYMENT INFORMATION

Are you presently employed? ☐ No ☐ Yes

If your answer is Yes, what kind of work do you currently do? _____

If your answer is No, is it because of your hearing loss? ☐ No ☐ Yes

Mark with an "X" how noisy your workplace is:

I ---------- I

Not Noisy Extremely Noisy

How often do you need to communicate at work? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Does your job depend on your ability to hear? ☐ No ☐ Yes

Describe how you most often communicate at work: _____

_____

_____

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TELL US HOW ARE YOU MANAGING YOUR HEARING LOSS

Who provides you with the most help with your hearing loss?

Name: _____

Relationship to you: _____

What kind of help do you receive from others?

Please check all that apply, and indicate who provides the support.

TYPE OF SUPPORT	Family	Friends	Employer	Social/Mental Health/Community Worker/Other
☐ Emotional	☐	☐	☐	☐
☐ Financial	☐	☐	☐	☐
☐ Transportation	☐	☐	☐	☐
☐ Activities of daily living (e.g. dressing/bathing)	☐	☐	☐	☐
☐ Daily household chores (e.g. cooking/cleaning)	☐	☐	☐	☐
☐ Communication with others	☐	☐	☐	☐

Are you currently having challenges managing your day-to-day living? ☐ No ☐ Yes

If your answer is Yes, please describe. _____

_____

Hearing loss can have an emotional impact on a person. It is normal to be frustrated, anxious, sad, and angry at times.

Do you find that it is becoming difficult to manage these feelings? ☐ No ☐ Yes

Do you want a second Cochlear Implant? ☐ No ☐ Yes ☐ Unsure

Do you have any concerns about getting another Cochlear Implant? ☐ No ☐ Yes

If your answer is Yes, please describe these concerns. _____

_____

_____

_____

Does anyone in your support network have any concerns about you getting a Cochlear Implant? ☐ No ☐ Yes

If your answer is Yes, please describe. _____

_____

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If you regularly wear a hearing aid with your cochlear implant, or wear your hearing aid with your cochlear implant sometimes, mark with an "X" below where you would rate your overall hearing ability to be when wearing your cochlear implant and hearing aid. If you are only wearing your CI and no longer wearing your hearing aid, please still indicate your hearing aid and indicate that it "CI only" under your marked X sign:

0% ---------- **100%**

Totally Deaf Normal Hearing

Mark with an "X" below where you would rate the percentage of hearing ability you expect to have when using a second cochlear implant?

0% ----------**100%**

Totally Deaf Normal Hearing

Describe what you want the second cochlear implant to do for you, should you be a candidate to receive it.