Cochlear Implant Center
6535 North Charles Street, Suite 250
Baltimore, Maryland 21204
(443) 849-8400

Patient History

Date: ________________

Name: ________________________________ **Age:** ______ **Sex:** ______

Social History

Marital Status:
____ SINGLE
____ MARRIED Spouses Name: ____________________
____ DIVORCED
____ WIDOWED

Occupation: ______________________ ____ Full-Time ____ Part-Time

School: ______________________

Services provided at school: ______________________

Religious Denomiation: ______________ Religious Practices: ______________

Hearing History

Reason for hearing loss: ______________________

Date Diagnosed with hearing loss: ____________

Currently using hearing aids? ____ **YES** RIGHT LEFT BOTH
____ **NO**

If yes, please list the make, model and serial numbers:

____

Age when hearing aid use began: ____________

Communication: **ORAL** **SIGN** **TOTAL COMMUNICATION**

Telephone Use: ____ **YES**
____ **NO**

Assistive Devices: (please circle all devices that you currently use)

Closed Captioning **Amplified Telephone** **Cap Tel** (Captioned Telephone)

Alerting/Flashing Device

Medical History (circle or check off, if pertinent to your history)

Smoking:	____	**YES**	Alcohol:	____	**YES**	Exercise:	____	**YES**	Pregnant:	____	**YES**
	____	**NO**		____	**NO**		____	**NO**		____	**NO**

Fever	Heart problems	Shortness of breath	Arthritis
Weight loss	Stroke	Difficulty breathing	Hives
Blurred vision	High blood pressure	Asthma	Skin disorder
Vision loss	High cholesterol	Stomach ulcer	Migraine headaches
Diabetes	Sinus infections	Acid reflux	Severe Nosebleeds
Dizziness	Trouble swallowing	Difficulty hearing	

Psychiatric disorder: ______________________________

Cancer: ______________________________

Previous Surgeries & Dates: (Ear, Nose, Throat, Eye, Stomach, Arm, Leg, etc…)

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Current Medications: (prescription AND over-the-counter)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Allergies: (drug, food and other)

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