COCHLEAR IMPLANT PROGRAM
PATIENT QUESTIONNAIRE

Patient's Name ……

Address ……

……

…….. Postal code ……..

Date of birth /…../…../…../ Gender….. OHIP # ……..... ……..
d m y Version

Hospital for Sick Children number (if available) # …….……

Name of Mother…….

Name of Father ……..

Name of Legal Guardian (if different from above).....……

Telephone # Home (…….) ……..……

Mother's Work (…….) ……

Father's Work (…….) ……

Mother's Cell (…….) ……..……

Father's Cell (…….) ……..……

Mother's E-mail address ……..……..……

Father's E-mail address ……

Cochlear Implant Program Coordinator

Room 6183, 6th Floor, Burton Wing
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario, Canada M5G 1X8
Fax: (416) 813-5036

****PLEASE ENCLOSE COPIES OF ALL AVAILABLE AUDIOGRAMS AND OTHER RELEVANT REPORTS****

COCHLEAR IMPLANT PROGRAM
PATIENT QUESTIONNAIRE

CIRCLE OF CARE

If your child is followed by any of the following professionals, please provide the name, address and phone number. List all that you've seen. Please include any reports with this application.

Audiologist: _____

_____

_____

Teacher of the Hearing-Impaired, Aural Habilitationist or Auditory-Verbal Therapist:

_____

_____

Speech-Language Pathologist: _____

_____

_____

Otolaryngologist (ENT Physician): _____

_____

_____

Family Physician or Paediatrician: _____

_____

_____

Other (e.g., Psychologist, Occupational Therapist, Physiotherapist, Infant Development Worker, etc.):_____

_____

_____

AUDIOLOGICAL INFORMATION

1) Is your child's hearing loss considered, overall, to be:

Right ear:	Mild ☐	Moderate ☐	Severe ☐	Profound ☐
Left ear:	Mild ☐	Moderate ☐	Severe ☐	Profound ☐

2) Was the hearing loss from birth? Yes ☐ No ☐ (If Yes, proceed to #5)

3) Was your child able to talk before he/she lost his/her hearing? …….

4) Approximate date of onset of hearing loss: right ear ……. left ear …….

5) Was the loss progressive? (has it become worse over time?) Yes ☐ No ☐

6) Is the hearing the same in both ears? Yes ☐ No ☐
   If No, which ear is worse? Right ☐ Left ☐

7) Cause of hearing loss (if known):
   …….....
   …….....

8) When and where was the hearing loss first diagnosed?
   ……..…….
   ……..…..

9) Is your child currently part of the province's Infant Hearing Program?
   Yes ☐ No ☐

HEARING AIDS

1) Does your child wear hearing aids? Yes ☐ No ☐

2) When did he/she start wearing hearing aids?_____

3) For how many hours does your child wear hearing aids each day?_____

4) Name and Model of hearing aids(s):

   Ear: Right _____ Left _____

SPEECH AND LANGUAGE

1) How does your child communicate (e.g., speech, sign language gestures)?

_____

2) Approximately how many words does your child understand now?

_____

3) Approximately how many words does your child use (say) now?

_____

4) Approximately how many signs does your child understand now?

5) Approximately how many signs does your child use now?

_____

Please indicate with a check mark how often the following occur:

My child vocalizes while playing alone or with others:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐

My child vocalizes to get someone's attention:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐

I understand my child's speech:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐ Not applicable ☐

Unfamiliar persons understand my child's speech:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐ Not applicable ☐

I understand my child's gestures:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐ Not applicable ☐

I understand my child's signs:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐ Not applicable ☐

My child combines speech and signs:
Almost always ☐ Often ☐ Sometimes ☐ Almost never ☐ Not applicable ☐

BIRTH HISTORY

Duration of pregnancy in weeks _____

Were there any illnesses or complications during pregnancy? Yes ☐ No ☐

If yes, please describe _____

Was labour normal? Yes ☐ No ☐

If no, please describe _____

Type of delivery (ex: vaginal, C-section)_____

Weight of child at birth _____

After the birth, was the child "blue"? Yes ☐ No ☐

Was oxygen required? Yes ☐ No ☐

Was your child in an incubator? Yes ☐ No ☐

If yes, for how long? _____

Was your child yellow or jaundiced after birth? Yes ☐ No ☐

Did your child have a blood transfusion after birth? Yes ☐ No ☐

Is there any known Rh blood incompatibility? Yes ☐ No ☐

MEDICAL HISTORY

Indicate if your child has had any of the following illnesses:

☐	Measles	☐	Mumps	☐	German Measles
☐	Scarlet Fever	☐	Flu	☐	High Fever
☐	Chicken Pox	☐	Whooping Cough	☐	Meningitis
☐	Diptheria	☐	Encephalitis	☐	Polio
☐	Epilepsy	☐	Allergies	☐	Ear infections
☐	Asthma				

Has your child had:

Serious accidents or injuries? Yes ☐ No ☐
If yes, please describe _____

Tubes inserted in ear drums? Yes ☐ No ☐

If yes, are they still in? Yes ☐ No ☐

Other surgery/hospitalizations Yes ☐ No ☐

If yes, what type and when? _____

_____

Has your child ever had Gentamicin, Streptomycin, Neomycin or Kanamycin or a similar antibiotic?

Yes ☐ No ☐ If yes, at what age, for what and for how long? _____

_____

Has your child ever had a CT, MRI scan or X-ray of his/her inner ear or cochlea?
Yes ☐ No ☐ If yes, please indicate when and where it was done _____

Has your child received IV antibiotics? Yes ☐ No ☐

Has your child received all routine immunizations? Yes ☐ No ☐

Has your child received the Prevnar vaccination? Yes ☐ No ☐

Has your child's vision been tested? Yes ☐ No ☐
If yes, when, where and what were results?

_____

DEVELOPMENTAL HISTORY

1) At what age did your child sit alone? _____
stand alone? _____
crawl? _____
walk alone? _____
babble? _____
say first word? _____

2) Does your child lose balance easily? Yes ☐ No ☐

3) Does your child have difficulty grasping objects? Yes ☐ No ☐

4) Does your child drool? Yes ☐ No ☐

5) Does your child have difficulty sucking, swallowing or chewing? Yes ☐ No ☐

6) Is your child toilet trained? Yes ☐ No ☐
If yes, when? _____

7) Can your child ride a bike? Yes ☐ No ☐
If yes, at what age? With training wheels _____
Without training wheels _____

8) Is your child right or left handed? Right ☐ Left ☐

9) Has your child had or been referred for a developmental assessment? Yes ☐ No ☐
(If one has been done, please provide a copy of the report.)

SOCIAL DEVELOPMENT

1) Does your child play well with other children? Yes ☐ No ☐
2) Does your child have temper tantrums? Yes ☐ No ☐
3) Is he/she withdrawn? Yes ☐ No ☐
4) Is your child able to concentrate? (does he/she have a good "attention span"?) Yes ☐ No ☐
5) Is your child very active? Yes ☐ No ☐
6) Is your child easily managed at home? Yes ☐ No ☐
7) Is your child easily managed at school? Yes ☐ No ☐
8) Does your child make good eye contact? Yes ☐ No ☐
9) Describe any behaviours of your child which may be of concern to you.

_____

_____

FAMILY HISTORY

Parents' current status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Common-law ☐ Single

Who has custody of the child? ☐ Mother and Father ☐ Mother ☐ Father ☐ Step parent ☐ Grandparent ☐ Other (please specify):_____

Language(s) spoken at home: _____

Brothers and sisters of the patient:

Name	Age	Sex	Hearing, Developmental, or Health Problems
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Is either parent currently receiving funding through Ontario Works or the Ontario Disability Support Program (ODSP)? Yes ☐ No ☐

Has an application for Assistance for Children with Severe Disabilities (ACSD) or Special Services at Home (SSAH) been made on your child's behalf?

Yes ☐ No ☐

Is the **father** or any of his family hard-of-hearing? Yes ☐ No ☐

If yes, who? _____ When was the loss discovered?_____

Is a hearing aid used? _____ If yes, from what age? _____

Is the **mother** or any of her family hard of hearing? Yes ☐ No ☐

If yes, who? _____ When was the loss discovered?_____

Is a hearing aid used? _____ If yes, from what age? _____

Are parents related? Yes ☐ No ☐ If yes, what is their relationship? _____

Has anyone in your family had genetic testing? Yes ☐ No ☐

If yes, who and for what? _____

Has your child or anyone in your extended family been diagnosed with a medical syndrome (e.g., Usher's, Waardenburg's)? Yes ☐ No ☐

If yes, who and what syndrome? _____

Does your child or anyone in your family have any of the following features?

	Child has feature	Family member has feature
Development Delay	☐	☐
Cerebral Palsy	☐	☐
Seizures/Convulsions	☐	☐
Abnormally shaped head	☐	☐
Hair has white patch	☐	☐
Hair loss	☐	☐
Eyes are different colours	☐	☐
Poor vision	☐	☐
Cataracts (haziness in lens of eye)	☐	☐
Abnormally shaped ears	☐	☐
Small dimples in front of ears	☐	☐
Cleft palate	☐	☐
Thyroid problems	☐	☐

continued on next page…

Goiter	☐	☐
Branchial cleft cyst (swelling on side of neck)	☐	☐
Heart defects	☐	☐
Chronic constipation	☐	☐
Obesity	☐	☐
Kidney problems	☐	☐
Skin rashes	☐	☐
Different coloured patches of skin	☐	☐
Fused fingers or toes	☐	☐
Low muscle tone	☐	☐
Unsteady when walking	☐	☐
Limb abnormality	☐	☐
Lower leg muscles underdeveloped	☐	☐
Frequent fractures of bone	☐	☐

If your child has not yet attended a school based program, you have completed the questionnaire. If your child has attended a school based program, please complete the education history.

EDUCATION HISTORY

Please list all of your child's school/therapy placements in order from first to most recent starting when your child was first fit with hearing aids.

PRE-SCHOOL PROGRAM(S)

Please include all types of programs in which your child was involved (ie. a school board home visiting program, individual therapy program, day care, nursery school, etc). Please continue on another page if necessary.

Program 1 _____

Starting Date_____ Ending Date_____

Teacher/Therapist_____ Telephone # _____

Communication Mode_____

Program 2 _____

Starting Date_____ Ending Date_____

Teacher/Therapist_____ Telephone # _____

Communication Mode_____

SCHOOL PROGRAM(S)

Please include all schools your child has attended and list the types of classes he/she has been enrolled in (ie. a self-contained class of a small number of children with hearing loss, classes with normally hearing children, etc).

School 1 _____

School Board _____

Telephone #(s) _____

Teacher (s) _____

Grade/Level _____ Communication Mode_____

Class type _____

Starting Date _____ Ending Date _____

School 2 _____

School Board _____

Telephone #(s) _____

Teacher (s) _____

Grade/Level _____ Communication Mode_____

Class type _____

Starting Date _____ Ending Date _____

School 3 _____

School Board _____

Telephone #(s) _____

Teacher (s) _____

Grade/Level _____ Communication Mode_____

Class type _____

Starting Date _____ Ending Date _____

(Please continue on another page if necessary.)

Does your child use an FM system at school? Yes ☐ No ☐

Does your child attend any classes with children who have normal hearing? Yes ☐ No ☐
If Yes, which classes are these? _____

Please list all other services that your child receives AT SCHOOL (ex: speech-language therapy, auditory-verbal therapy, occupational therapy, etc).

_____

Please list all other services that your child receives OUTSIDE OF SCHOOL (ex: speech-language therapy, auditory-verbal therapy, physiotherapy, etc).

_____

Please list any organized activities that your child is involved with (ex: sports, music, arts and crafts groups).

_____

Has your child ever had or been referred for a psychoeducational assessment? Yes ☐ No ☐
(If one has been done, please provide a copy of the report.

Thank you for completing the questionnaire.

Please mail or fax this questionnaire to:

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