**Cisplatin-associated ototoxicity amongst patients receiving cancer chemotherapy and the feasibility of an audiological monitoring program**

**INTERVIEW QUESTIONNAIRE FOR PATIENTS**

DATE:

## 1. PERSONAL INFORMATION

CODE

BIRTHDATE: AGE:

RACE GENDER:

AUDIOLOGICAL EVALUATION: BASELINE: CYCLE 4:

FOLLOW UP: 1 3 6

## 2. HEARING HISTORY

2.1. Do you experience hearing difficulties? Yes No

2.2. When did you first notice the problem?

2.3. In which ear do you experience these difficulties?

| Left | Right | Both |
|---|---|---|

2.4. Do you experience any pain in your ears? Yes No

2.5. Do you hear noises in your ears or head? Yes No

2.5.1. How long have you been hearing these noises?

| | | |
|---|---|---|
| < 1 week | 1 week | |
| 2 weeks | 1 month | 2 months |
| 3 months | < 6 months | 6 months |
| < 1 year | >1 year | |

2.5.2. Where is the noise present?

| Head | Left Ear | Right ear | Both ears |
|---|---|---|---|

2.5.3. Describe the sound.

| High pitched | Low pitched | Ringing | Pulsating | Roaring |
|---|---|---|---|---|

2.5.4. When do you hear this sound?

| Morning | Midday | Afternoon | Night |
|---|---|---|---|
| All the time | | | |

2.5.5. Is it present?

| Continuously | Intermittently |
|---|---|

2.5.6. Describe the loudness of these noises

| Not loud at all | Slightly loud | Moderately loud | Very loud |
|---|---|---|---|

**2.5.7. Has these noises changed since you started the treatment

| Yes | No |
|---|---|

**2.5.8. Has the loudness of these noises changed?

| Yes, louder now | Yes, quieter now | No |
|---|---|---|

2.6. Do you ever have a feeling of fullness or stuffiness in your ears?

| Yes | No |
|---|---|

## 3. OTOLOGIC HISTORY

3.1. Have you ever had any repeated ear infections?

| Yes | No |
|---|---|

3.1.1. Which ear?

| Right | Left | Both |
|---|---|---|

3.2. Have you had any surgery on your ears?

| Yes | No |
|---|---|

3.2.1. If yes, please specify what surgery as well as the date. DATE

SURGERY

3.3.Have you ever had any injury to the head or neck region?

| Yes | No |
|---|---|

3.4.If so, provide details

## 4. FAMILY HISTORY

4.1. Does anyone in your family have a hearing loss? | Yes | No |

4.2. If so, who? |

4.3.What was the cause of the hearing loss? |

## 5. GENERAL MEDICAL HISTORY (To be completed in conjunction with review of patients medical records)

5.1. Do you suffer from any other medical conditions? | Yes | No |

5.2. Name the conditions. |

5.3. Have you ever been diagnosed with Tuberculosis (TB) and/or malaria? | Yes | No |

5.4. When were you diagnosed with cancer? |

5.5. Did you receive any other treatment for the cancer? | Yes | No |

5.5.1. If so, what treatment did you receive? | Surgery | Radiation therapy | Both |

**MEDICAL REVIEW**

5.6. Type of cancer: _____

5.7. Stage of cancer: _____

5.8. List all the medication and dosage.

| Medication | Dosage |
|---|---|
| | |

5.9. Renal function: _____

5.10. Current weight: _____

## 6. NOISE EXPOSURE HISTORY

6.1. Have you ever been exposed/or are exposed to loud noise for long periods of time?

| Yes | No |
|---|---|
| | |

6.2. If yes, please specify the type of noise? | |

** - denotes questions to be asked if the patient had experienced tinnitus prior to commencement of chemotherapy.