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

**INTERVIEW QUESTIONNAIRE FOR PATIENTS**

**DATE:**

### 1. PERSONAL INFORMATION

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<th>CODE</th>
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<table>
<thead>
<tr>
<th>BIRTHDATE:</th>
<th>AGE:</th>
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<table>
<thead>
<tr>
<th>RACE</th>
<th>GENDER:</th>
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**AUDIOLOGICAL EVALUATION:**

<table>
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<tr>
<th>BASELINE:</th>
<th>CYCLE 4:</th>
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### 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?

<table>
<thead>
<tr>
<th>&lt;$1$ week</th>
<th>$1$ week</th>
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<table>
<thead>
<tr>
<th>2 weeks</th>
<th>1 month</th>
<th>2 months</th>
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<table>
<thead>
<tr>
<th>3 months</th>
<th>&lt;$6$ months</th>
<th>6 months</th>
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<table>
<thead>
<tr>
<th>&lt;$1$ year</th>
<th>&gt;$1$ year</th>
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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.

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<tr>
<th>Medication</th>
<th>Dosage</th>
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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.