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SCREENING MEDICAL HISTORY QUESTIONNAIRE: DETERMINING CANDIDACY FOR THE MAXUM HEARING IMPLANT

Name: _____

Address:_____City_____St_____Zip_____

Phone/Mobile number: (____)_____Email address: _____

1. Have you had any of the following (Please explain):
    a. Heart disease? Heart attack? Coronary artery bypass surgery? Chest pain? Irregular heart beat? Circulation problems? High blood pressure? Heart transplant?

    b. Lung disease? Breathing problems? Asthma? Do you use inhalers? Do you have sleep apnea or use a CPAP machine to help you breathe? Bronchitis or emphysema?

    c. Kidney disease or kidney failure? Kidney transplant(s)?

    d. Blood clotting disorder? Take any blood thinners? Coumadin, Plavix, Lovenox, Aspirin, etc? Do you have anemia?

e. Strokes? Seizures? Neurosurgical operations?

f. Have you had any stomach, intestinal or bowel diseases?

g. Chronic bacterial infections? Staphylococcal infections? HIV aids? Tuberculosis?

h. Diabetes? Take pills for diabetes, inject insulin or use an insulin pump?

i. Complications from anesthesia during or after surgery? High fevers, long wake up times, or difficult intubation?

j. Have you had any ear operations such as repair of your ear drum or hearing bones, replacement of your stapes (stapedectomy), ear tubes, mastoid surgery, etc. ? Vertigo? Tinnitus? Ear pain? Ear drainage? Chronic ear canal infections or abscesses? Been told that you have small ear openings or small ear canals?

k. Do you have significant sinus disease? Have you had any sinus surgery? Do you have significant allergies, hay fever, etc.

l. Have you had recent fevers, weight loss or night sweats?

m. Have you been treated for any types of tumors or cancers? Have you ever or are you receiving any chemotherapy? Radiation therapy?

2. Do you require magnetic resonance imaging (MRI) scans in the future for any medical conditions?

3. Do you feel your general health is good?

4. When is the last time you had a physical evaluation? Last blood count, chest x-ray, electrocardiogram (ECG), etc.?

5. Has your hearing been fluctuating or deteriorating rapidly? Does anyone in your family have complete deafness or has anyone had a cochlear implant?

6. Do you have ringing in your ears? Does it keep you awake at night, keep you from falling asleep, or awaken you once you have fallen asleep?

7. Have you had or do you have any psychiatric illnesses?

8. What medications do you take (including aspirin, oral contraceptives, etc.)? Do you have any allergies to medications(pain killers or narcotics, antibiotics, etc.?). Any other substance allergies such as latex, vaccines, foods, contrast dyes, etc.)?

9. Is there anything else about your medical history that you would like to tell us about or that you think that we should know about you?

10. Please PRINT the name, address, and phone number of your family doctor or internist.

Name: _____

Address:_____City:_____St:_____Zip _____

Phone: _____

Please Note: <u>The purpose of this screening medical questionnaire is to help determine if you are a surgical candidate for the MAXUM Hearing Implant. A final determination for candidacy can only be determined by your surgeon after: (1) additional medical history has been obtained, (2) a physical examination, particularly of your ears, has been completed, and (3) you have undergone a comprehensive hearing evaluation by your surgeon's audiologist(s).</u>