SCREENING MEDICAL QUESTIONNAIRE PRIOR TO ENVOY ESTEEM IMPLANTATION

Protocol 0204, Site 103

The Ear Center of Greensboro, P.A.

Name: _____

Phone number: _____

Email address: _____

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

    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? Kidney transplant(s)?

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

e. Strokes? Seizures? Neurosurgical operations?

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

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

h. Diabetes? Take insulin or use an insulin pump?

i. Complications from anesthesia after surgery? High fevers, long wake up times?

j. Have you had any ear operations? Vertigo? Tinnitus? Ear pain? Ear drainage?

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 had any types of tumors or cancers?

2. Do you require magnetic resonance imaging (MR) 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 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?

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

8. What medications do you take? Do you have any allergies (medications, latex, vaccines, foods, 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.

11. Name: _____

12. Address: _____

13. Phone: _____