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COVID-19 Case History Questionnaire

Andreea Hajas

Sumit Agrawal
Western University

Ioan Curca
Western University

Paula Folkeard
Western University, pfolkea@uwo.ca

Robert Guadagno

See next page for additional authors

Authors

Andreea Hajas, Sumit Agrawal, Ioan Curca, Paula Folkeard, Robert Guadagno, A Jennings, Sheila T F Moodie, Mohamed Rahme, Sangamanatha Veeranna, Andreas Seelisch, Divya Sundaravadivelu, and Susan Scollie

COVID-19 AND AUDIO-VESTIBULAR HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your record.

Name *(Last, First):*	**Date of Birth:**

PART A: COVID-19 INFECTION HISTORY

1. Have you ever received a positive COVID-19 test (PCR, rapid)?			☐ Yes	☐ No		
2. If yes, was a variant of concern/interest (ex. Delta) identified? If yes, which one?	☐ Yes	☐ No	☐ Do not know			
3. If yes, did you have any of the following COVID-19 symptoms? Select all that apply.						
Loss of taste or smell	☐					
High fever	☐					
Body ache	☐					
Skin changes (rashes, hives, bumps, discoloration around fingers or toes)	☐					
Confusion	☐					
Eye problems (pink eye)	☐					
Gastrointestinal symptoms	☐					
4. When did you first notice your COVID-19 symptoms? **Date:**						
5. Were you admitted to hospital as a result of your COVID-19 infection?			☐ Yes	☐ No		
5a. If yes, how long was your stay at the hospital?						
6. Were you administered medications that you were told could harm your hearing or balance? If yes, which one	☐ Yes	☐ No	☐ Do not know			
7. If admitted to hospital, did you require equipment to help you breathe (for example, BiPAP, intubation, respirator)?			☐ Yes	☐ No		
8. Do you have lasting symptoms related to COVID-19 (referred to as being a COVID-19 Long-Hauler)?			☐ Yes	☐ No		
8a. Describe any on-going symptoms:						

PART B: PRE-COVID-19 INFECTION HEALTH HISTORY

9. Prior to your COVID-19 infection, did you ever have your hearing tested?			☐ Yes	☐ No		
9a. If yes, did you have an identified hearing, tinnitus, balance, or dizziness problem? Please describe:			☐ Yes	☐ No		
9b. Do you use hearing aids?			☐ Yes	☐ No		
10. Do you have any of the following conditions? Check all the following that apply to you.						
Cardiovascular disease (coronary heart disease, congenital heart disease)	☐					
Stroke	☐					
High Blood pressure	☐					

Diabetes type 1 or 2	☐
Chronic Kidney disease	☐
Chronic Obstructive Pulmonary Disorder (COPD)	☐
Immunodeficiency disease - please specify: _____	☐
Sickle cell disease	☐
Smoking (tobacco, marijuana, vape	☐
Pregnancy	☐
Other:	

PART C: POST-COVID-19 INFECTION HEALTH HISTORY

11. After your COVID-19 infection, did you experience any of the following? Check all that apply.	
Pain in ear	☐
Migraines	☐
Increased vocal strain (talking louder than normal)	☐
Aural fullness	☐
Difficulty understanding speech in background noise	☐
Other: _____	

12. Have you noticed changes to your hearing since having COVID-19?					☐ Yes	☐ No	
12a. If yes, is the change in:	☐ Left Ear Only	☐ Right Ear Only	☐ Both Ears				
12b. If yes, please describe the change in your own words:							
12c. If yes, were hearing changes sudden?	☐ Within Days	☐ Within Hours	☐ Within Minutes	☐ No			
13. Have you noticed changes in any of the following: balance, vertigo, spinning, falls, light-headedness, dizziness?					☐ Yes	☐ No	
13a. If yes, were the changes sudden?	☐ Within Days	☐ Within Hours	☐ Within Minutes	☐ No			
13b. If yes, select the type of dizziness that best describes your experience:							
Feeling of spinning while lying down or rolling in bed							☐
Feeling of spinning in the head while still, not associated with changing position (standing up from sitting)							☐
Light headedness							☐
Other:							
14. If you had buzzing, ringing, other noises (tinnitus) prior to COVID-19, has it become louder or more frequent?					☐ Yes	☐ No	
15. Have you noticed any new buzzing, ringing, or other noises (tinnitus) since having COVID-19					☐ Yes	☐ No	
15a. If yes, is it in:	☐ Left Ear Only	☐ Right Ear Only	☐ Both Ears				
15b. If yes, is it:	☐ There All The Time	☐ Come-And-Go	☐ Not Sure				
15c. If yes, was it sudden?	☐ Within Days	☐ Within Hours	☐ Within Minutes	☐ No			