comprehensiveENT care for all ages

HEALTH QUESTIONNAIRE

To be completed by patient (parent/guardian if under 18). Please print.

Patient Name: ______________________________ Date: ______________

Reason for visit: ______________________________

Personal Medical History (Check if current or past problem)

Respiratory System
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other

Endocrine System
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Other

Neurologic System
- ☐ Stroke
- ☐ TIA
- ☐ Headaches
- ☐ Seizures
- ☐ MS
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Other

Hematologic System
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Other

Rheumatologic Disorder
- ☐ RA
- ☐ Lupus
- ☐ Other

Other
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Glaucoma
- ☐ Allergic Rhinitis

Cardiovascular System
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Heart Disease
- ☐ Heart Attack

Gastrointestinal System
- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Heartburn
- ☐ Indigestion
- ☐ GERD
- ☐ Other (Crohn's/Celiac/UC)

Anesthesia Complications
- ☐ Type? ______________

Urologic System
- ☐ Kidney Disease/Issues
- ☐ Prostate Hypertrophy
- ☐ Other

Infectious Diseases
- ☐ HIV
- ☐ Hepatitis
- ☐ MRSA

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Other

Cancer
- ☐ Type? ______________

Surgical History: ______________________________

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Current Medications (Include dosage and those you buy without a prescription.)

Medication/Dosage	***Medication/Dosage***

Allergies

Do you have any allergies to medications or other substances? ☐ Yes ☐ No ☐ Don't Know

If yes, please list: ______________________________

Social History

Do you now or have you ever used cigarettes or other tobacco products?

☐ Non-smoker ☐ Former smoker ☐ Current daily smoker ☐ Occasional smoker

If yes, for how long? ______________ Years

If you formerly smoked or used tobacco products, how long ago did you quit? ______________ Years

Do you drink alcohol?

☐ Never ☐ Socially ☐ 1-2 drinks a day ☐ 3 or more drinks a day ☐ Other ______________

Do you drink caffeine (coffee, tea, soda)?

☐ Never ☐ Occasionally ☐ 1-2 cups a day ☐ 3 or more cups a day ☐ Other ______________

Review of Symptoms

Please check if you are currently experiencing any of the following symptoms.

Constitutional

☐ Fever/Chills
☐ Fatigue
☐ Weight Loss
☐ Weight Gain
☐ Night Sweats
☐ All Negative

HEENT

☐ Choking
☐ Dizziness
☐ Difficulty Swallowing
☐ Ear Drainage
☐ Hoarseness
☐ Mouth Ulcers
☐ Ear Pain
☐ Sore Throat
☐ Ringing in Ears
☐ Vertigo
☐ Visual Changes
☐ Hearing Loss
☐ Itchy Ear
☐ Ear Popping
☐ Imbalance
☐ Sinus Pressure
☐ Nose Bleeds
☐ Nasal Congestion
☐ Post Nasal Drip
☐ Sneezing
☐ Itchy Eyes/Nose
☐ Sensation of Lump in Throat
☐ Neck Pain/Arthritis
☐ Clenching/Grinding Teeth
☐ All Negative

Respiratory

☐ Apnea During Sleep
☐ Shortness of Breath
☐ Snoring
☐ Wheezing
☐ Coughing
☐ All Negative

Gastrointestinal

☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Indigestion
☐ Vomiting
☐ All Negative

Cardiovascular

☐ Chest Pain
☐ Heart Murmur
☐ Palpitations
☐ All Negative

Metabolic/Endocrine

☐ Cold Intolerance
☐ Heat Intolerance
☐ Increased Thirst
☐ All Negative

Genitourinary

☐ Change in Urine Color
☐ Pain with Urination
☐ Urinary Frequency
☐ All Negative

Neurological

☐ Difficulty Falling Asleep
☐ Difficulty Staying Awake
☐ Excessive Daytime Sleepiness
☐ Non-Restorative Sleep
☐ Numbness in Extremities
☐ Feeling Faint Light-Headed
☐ Tingling
☐ Tremors
☐ Weakness
☐ Headaches
☐ All Negative

Psychiatric

☐ Anxiety
☐ Depression
☐ Hallucinations
☐ All Negative

Family History

Please check any of the following diseases or conditions that have occurred in any family member.
(Please do not include family members by marriage or adoption.)

- ☐ Thyroid Disease
- ☐ Migraines
- ☐ Asthma
- ☐ Complications with Anesthesia
- ☐ Mental Illness
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Stroke
- ☐ Heart Disease
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ MS
- ☐ High Blood Pressure
- ☐ Childhood Hearing Loss
- ☐ Cancer (Type?) ______________________________

Patient Signature: ____ Date: ___________________________