ENT FACULTY PRACTICE - PATIENT QUESTIONNAIRE

Dear Patient,

Please answer the following medical questions. ***Please be reassured that patient privacy is a top priority!***

Date:______________________________________

Name: ___________________________________D.O.B.______________ Age: ________________

Occupation:____

Reason for Visit? ____

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Length of time you had this problem:____

Name:______________________________________**D.O.B**______________

Have you ever had any of these medical problems in the **PAST** (please check all that apply)?

☐ **Check Here, If No Past Medical Problems.**

CARDIOVASCULAR: ☐ **NONE**	☐ Coronary Artery Disease ☐ Heart Surgery	☐ Elevated Cholesterol ☐ High Blood Pressure	☐ Heart Attack
EYE/EAR/NOSE/THROAT: ☐ **NONE**	☐ Cataracts ☐ Hearing Loss ☐ Sinus Problems	☐ Glaucoma ☐ Nasal Polyps ☐ Tinnitus	☐ Chronic Ear Infections ☐ Recurrent Acute Tonsillitis ☐ Vertigo
GASTROINTESTINAL: ☐ **NONE**	☐ Hepatitis ☐ Liver Disease	☐ Hernia (Hiatal)	☐ GERD (Gastroesophageal Reflux)
PULMONARY: ☐ **NONE**	☐ Asthma ☐ Sleep Apnea	☐ COPD	☐ Tuberculosis
GENITOURINARY: ☐ **NONE**	☐ Prostate Enlargement ☐ Hernia	☐ Kidney Stones	☐ Acute Renal Failure
HEMATOLOGIC: ☐ **NONE**	☐ Bleeding Disorder	☐ Anemia	
INFECTIOUS DISEASE: ☐ **NONE**	☐ HIV/AIDS ☐ Bronchitis	☐ Mononucleosis ☐ Pneumonia	☐ STD Type:_______________
METOBOLIC/ENDOCRINE: ☐ **NONE**	☐ Diabetes Type: ___________	☐ Thyroid Deficiency (Hypothyroidism)	☐ Thyroid Excess (Hyperthyroidism)
CANCER: ☐ **YES** ☐ **NO**	Enter Type:_________	Enter Type:_____________	Enter Type: ______________
NEUROLOGIC: ☐ **NONE**	☐ Migraines ☐ Seizures	☐ Other Disorder (Parkinson's, Alzheimers, ALS, MS): Enter Type: ________________________	☐ Stroke ☐ Neuropathy
OBSTETRIC: ☐ **NONE**	☐ Complications During Pregnancy	☐ Complications During Delivery	☐ Preterm Birth
PSYCHIATRIC: ☐ **NONE**	☐ Adjustment Disorder - Anxiety	☐ Major Depressive Disorder	
AUTOIMMUNE DISEASE: ☐ **NONE**	Type_____________		

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: ☐ **NONE**

For any indicated Medical problems was surgery performed (fill in as much information as possible)? ☐ NONE

Date or Age:________ **Facility:**________________ **Treatment/Surgery:**___________________**Physician:**_______________

Date or Age:________ **Facility:**________________ **Treatment/Surgery:**___________________**Physician:**_______________

Date or Age:________ **Facility:**________________ **Treatment/Surgery:**___________________**Physician:**_______________

Name: ___________________________ D.O.B ________

Medications:

List medications and vitamins that you take on a regular basis. ☐ **NONE**
(Please include Supplements, Homeopathic, Herbal and Over The Counter Medicines)

Medication:_____________ Dosage(if known):____ Medication:_____________ Dosage(if known):____
Medication:_____________ Dosage(if known):____ Medication:_____________ Dosage(if known):____
Medication:_____________ Dosage(if known):____ Medication:_____________ Dosage(if known):____

Allergies:

☐ **Check Here, If No Known Food Allergies.**
☐ **Check Here, If No Known Environmental Allergies.**

Do you have any of the following Food or Environmental Allergies (please check all that apply)?

☐Adhesive Tape	☐Beans	☐Dairy	☐Dogs ☐Cats
☐Eggs	☐Feathers	☐Seafood (fish)	☐Latex
☐Peanuts ☐Dustmites	☐Pollen ☐Trees/Grass	☐Rag Weed ☐Mold	☐Other: _________________________

☐ **Check Here, If No Known Drug Allergies.**

Do you have any of the following Drug Allergies (please check all that apply)?

☐Ace Inhibitors	☐Aspirin	☐Codeine	☐Macrolides (Mycin Drugs)
☐Sulfas	☐IVP Dye, Iodine Containing	☐NSAIDS (Motrin/Advil/Ibuprofen)	☐Penicillin's
☐Tetracyclines	☐ Tylenol	☐Other: ______________	☐Other: ______________

Have you ever had any problems or reactions to Anesthesia? ☐ NO ☐ YES **If yes, please explain:**____
____

Social History:

Do you, or have you ever smoked? ☐ **N/A**

☐ I've Never Smoked	☐ Currently Smoke Cigars
☐ A Former Smoker - ___ Pack(s)/Day Age Started:_____	Age Stopped:___________ Year Quit:_____________
☐ Currently Smoke Cigarettes - ___ Pack(s)/Day	☐ Currently Smoke a Pipe

Do you drink alcohol (please check)? ☐ **N/A**

☐ Rarely or Never	☐ Drink Daily
☐ Occasionally (Social)	☐ Former Alcohol Intake, None For ____ Years.

Do you use recreational drugs? ☐ **Yes** ☐ **No** ☐ **N/A**

☐ Amphetamines Dates of use _________ to _________	☐ Intravenous Drugs Type: ____________________ Dates of use _____________to ______________
☐ Barbituates Dates of use _________ to _________	☐ Marijuana Dates of use _________ to ________
☐ Cocaine/Crack Dates of use _________ to _________	☐ MDMA (Ecstasy) Dates of use _______ to _____

Are you presently or have you ever been exposed to a second hand smoke hazard?

☐ No	☐ Yes – (circle one, or both) Presently Past

Do you consume caffeine?

☐ Yes (Circle): Coffee Tea Other Beverage(s)	☐ No

What is Your Water (H_2O) Intake? If so, how much…

________ (Circle One): Glasses/Ounces Per Day/Unknown

Name: _____________________________ D.O.B. __________

Family History (Please Place Check Marks Below):

If history unknown check here ☐

RELATION: / FAMILY HISTORY OF:	CHILD	PARENT	SIBLING	GRANDPARENT	OTHER RELATIVE
ADD-Attention Deficit	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Alzheimer Disease	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐
Migraines (Common)	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐

Please enter if anyone in your family (child, parent, grandparent, sibling, other relative) has had the Same or Similar ENT (ear, nose, throat) related problem as the reason for your visit: ☐ NONE

Problem: _____________________________ **Family Member(s):**_____________________________

Problem: _____________________________ **Family Member(s):**_____________________________

Problem: _____________________________ **Family Member(s):**_____________________________

Name: ______________________________ D.O.B. _______

"**Review of Systems**":

Put a check next to the medical issues you CURRENTLY have, fill in "Other", or "No Problems":

Constitutional: ☐ **No Problems** _☐ Fever ☐ Chills ☐ Night Sweats ☐ Dizziness
Other:____

Cardiovascular: ☐ **No Problems** ☐ Chest Pain ☐ Swelling of Extremities ☐ High Blood Pressure
Other:____

Endocrine: ☐ **No Problems** ☐ Thyroid Problem ☐ Diabetes
Other:____

Eyes: ☐ **No Problems** ☐ Blurry Vision ☐Double Vision ☐ Itchiness ☐ Blindness ☐ Photophobia
Other:____

Gastrointestinal: ☐ **No Problems** ☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Liver Problem ☐ Diarrhea
Other:____

Respiratory: ☐ **No Problems** ☐ Asthma ☐ Pneumonia ☐ Cough ☐ Sputum ☐ Wheezing ☐ Tuberculosis
Other:____

Genitourinary: ☐ **No Problems** ☐ Bleeding ☐ Burning ☐ Kidney Stones ☐ Prostate Problem
Other:____

Hematologic: ☐ **No Problems** ☐ Easy Bruising ☐ Anemia ☐ Clotting Problem
Other:____

Immunologic: ☐ **No Problems** ☐ HIV Positive ☐ AIDS
Other:____

Lymphatic: ☐ **No Problems** ☐ Nodes ☐ Lumps
Other:____

Musculoskeletal: ☐ **No Problems** ☐ Pain ☐ Swelling ☐ Weakness ☐ Stiffness ☐ Arthritis
Other:____

Neurological: ☐ **No Problems** ☐ Numbness ☐ Memory Problems ☐ Vertigo
Other:____

Ob/Gyn (females only): ☐ **No Problems** ☐ Pregnant ☐ Irregular Periods ☐ Discharge
Other:____

Psychiatric: ☐ **No Problems** ☐ Depression ☐ Anxiety ☐ Hallucinations ☐ Suicidal Tendency ☐ Drug Addiction
Other:____

Skin: ☐ **No Problems** ☐ Rash ☐ Lesion ☐ Pain
Other:____