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:_____