Otolaryngology Patient Questionnaire

Please print legibly

Patient Name: ____________________ Date of Birth: ____________ Today's Date: __________

Primary Phone #: (_____) __________ Secondary Phone #: (_____)__________ Work / Other # Phone #: (_____) __________

Reason for visit: ____________________

Primary Care Physician: ____________________ Phone (   )__________

Referring Physician: ____________________ Phone (   ) __________

Pharmacy Name: __________ Phone ( )__________ Address: __________

Allergies: □ Latex □ Tape □ Food □ None

Medication allergies: ____________________

____

Allergy reaction(s): ____________________

____

Do you smoke? □ No □ Yes Chew? □ No □ Yes

□ Cigarettes □ Cigars □ Pipe □ E Cig __________

Other__________

If yes, how much? ________ How long? ________

Are you a former smoker? □ No □ Yes __________ (Date Quit)

How much did you? ________ How long? ________

Do you drink alcohol? □ No □ Yes

If yes, how much and how often do you drink?

________ per __________

\# of drinks (day, week, month or year)

Have you ever used intravenous or recreational drugs?

□ No □ Yes

If yes, please list: ____________________

When was your last flu vaccination? __________

Who gave you the flu vaccination?__________

When was your last pneumonia vaccination?__________

Who gave you the pneumonia vaccination?__________

Have you fallen this year? □ No □ Yes

Are you afraid of falling or unsteadiness? □ No □ Yes

Would you like to speak to someone about fall prevention?

□ No □ Yes

Please list all current prescription medications:

(Or bring list of meds)

Name	Dose	Reason for taking it

List over the counter: (Tylenol, antihistamines, herbals, fish oil, all vitamins, etc.)

Name	Dose	Reason for taking it

Are you on blood thinners? □ No □ Yes

Please list current illnesses/health problems: ________

____

____

____

____

Please list surgeries and hospitalizations:	**Year**

Review of Systems

Please circle any symptoms below that you feel are affecting your health.

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts.

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing.

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Other: ____

Personal/Family Medical History

Please check where you or members of your family, have had the following:

	Yourself	Father	Mother	Father's Side	Mother's Side	Brother(s)	Sister(s)
AIDS/HIV							
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bleeding Problem							
Bone Fracture							
Cancer							
Cirrhosis							
Dementia							
Depression							
Diabetes Mellitus							
Eczema, Hives Rash							
Eye Problem/Glaucoma							
Heart Disease/Murmur							
Hemophilia							
Hearing Loss							
High/Low Blood Pressure							
High Cholesterol							
Kidney/Bladder Problem							
Liver Disease/Jaundice							
Lung Disease							
Mental Illness							
Osteoporosis							
Parkinson's Disease							
Peptic Ulcer Disease							
Phlebitis/Blood Clot							
Rheumatic Fever							
Seizures/Epilepsy							
Sickle Cell Disease							
Stroke							
Thalassemia							
Thyroid Disease							
Tuberculosis							

Other: ____

____

Information on both pages will be entered into EHR and paper document shredded.

Form completed by: ______________________________

(if other than patient)

Relationship to patient: ______________________________