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:** _____

_____

**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: _____