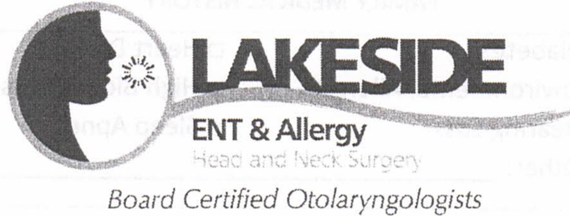
Date: ______________

Account # ____________



Board Certified Otolaryngologists

MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we can provide you with the best of care

Patient Name: ______________________________ DOB: / / Age: ______
Please Print Last First

Reason for Visit: ______________________________ Gender: ___ Male ___ Female

Patient Home Phone Number: ____________________ Cell: ____________________

Occupation: ______________ Patient Accompanied By: ____________________

PHARMACY INFORMATION:
Name: ______________________________ Address: ______________________________

Primary Care Provider: ____________________ Doctor who Sent you here: ______________

PAST MEDICAL HISTORY

- ☐ ADD
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth History (ie Preemie, c-section, low birth weight) ______________ ______________
- ☐ Bleeding Disorders
- ☐ Cancer (skin, thyroid, etc) Type: ________
- ☐ Depression/Anxiety
- ☐ Diabetes, Type I or II (Please circle I or II)
- ☐ Dizziness
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Gastric Reflux
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Lipids
- ☐ HIV
- ☐ Hoarseness
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraine Headaches
- ☐ Nasal Obstruction
- ☐ Restless Leg Syndrome
- ☐ Sleep Apnea
- ☐ Prior Sleep Study When: __________ Where: __________
- ☐ Sinusitis
- ☐ Snoring
- ☐ Stomach Ulcer
- ☐ Strep Throat
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ Disorder
- ☐ Tonsillitis

☐ No Pertinent History ☐ Other: ______________________

PAST SURGICAL HISTORY

Please include dates of surgery

- ☐ Ear Surgery ________
- ☐ Facial Surgery ________
- ☐ Nasal/Sinus Surgery ________
- ☐ Other ______________________________
- ☐ Neck Surgery (i.e. thyroid) ________
- ☐ Skin Lesion/Cancer Surgery ________
- ☐ Tonsillectomy/Adenoidectomy ________
- ☐ Vocal Cord Surgery ________

MEDICATION HISTORY

List current medications and dosage:

____

____

DRUG ALLERGIES

Drug Allergies: ☐ No Known Drug Allergies ☐ Yes (if yes, please list and include reaction)

____

FAMILY MEDICAL HISTORY

- ☐ Bleeding Disorders
- ☐ Cancer
  Type: ________________
- ☐ Family History Unknown
- ☐ Diabetes
- ☐ Environmental Allergies
- ☐ Hearing Loss
- ☐ Other: ____________________
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sleep Apnea
- ☐ Thyroid Cancer
- ☐ Thyroid Disease

SOCIAL HISTORY

Alcohol Usage

- ☐ Currently Every Day
  Amount: ________ Type: ________
- ☐ Currently Some Days
  Amount: ________ Type: ________
- ☐ Former Age Quit: ______
- ☐ Never

Tobacco Usage

- ☐ Currently Every Day
  Amount: ________ Type: ________
- ☐ Currently Some Days
  Amount: ________ Type: ________
- ☐ Former Age Quit: _____
- ☐ Never

Other

- ☐ Do you live alone? (check for yes)
- ☐ Prior or Current Recreational Drug Use
- ☐ Other Risk Factors for HIV
  Explain: ____________________

REVIEW OF SYSTEMS

Please check all symptoms which you have, or have had recently. If you have not experienced a medical problem under the symptom listed, check the NO Box.

CONSTITUTIONAL SYMPTOMS

☐ fatigue ☐ fever ☐ difficulty sleeping

Other: ____________________

☐ No Constitutional Symptoms

EYE SYMPTOMS

☐ eye discomfort ☐ changes in vision

Other: ____________________

☐ No Eye Symptoms

CARDIOVASACULAR SYMPTOMS

☐ chest pain ☐ irregular heart beats

☐ lightheadedness

Other: ____________________

☐ No Cardiovascular Symptoms

PSYCHIATRIC SYMPTOMS

☐ anxiety ☐ depression

Other: ____________________

☐ No Psychiatric Symptoms

RESPIRATORY SYMPTOMS

☐ shortness of breath ☐ hoarseness ☐ cough

☐ wheezing

Other: ____________________

☐ No Respiratory Symptoms

INTEGUMENT (SKIN) SYMPTOMS

☐ new skin lesions ☐ lumps

☐ change in mole appearance

Other: ____________________

☐ No Integument (skin) Symptoms

ALLERGIC-IMMUNOLOGIC SYMPTOMS

☐ environmental allergies ☐ immune deficiency

Other: ____________________

No Allergic Immunological Symptoms

NEUROLOGICAL SYMPTOMS

☐ speech difficulties ☐ migraines ☐ dizziness ☐ headaches

☐ seizures ☐ numbness/tingling Other:

____

☐ No Neurologic Symptoms

MUSCULOSKELETAL SYMPTOMS

☐ muscular weakness ☐ twitching ☐ gait changes

☐ joint pain

Other: ____________________

☐ No Musculoskeletal Symptoms

ENDOCRINE SYMPTOMS

☐ weight gain ☐ weight loss ☐ history of thyroid problems

☐ hot or cold intolerances

Other: ____________________

☐ No Endocrine Symptoms

GASTROINTESTINAL SYMPTOMS

☐ nausea ☐ heartburn ☐ difficulty swallowing

☐ choking on liquids ☐ reflux

Other: ____________________

☐ No Gastrointestinal Symptoms

HEME (BLOOD) – LYMPH SYMPTOMS

☐ swollen lymph nodes ☐ easy bleeding or bruising

Other: ____________________

☐ No Hemo(blood)-Lymph Symptoms

OTHER PERTINANT INFORMATION WE SHOULD KNOW