



**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)

<u>Name</u>	<u>Dose</u>	<u>Reason for taking it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Name</u>	<u>Dose</u>	<u>Reason for taking it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

	Yoursel	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: \_\_\_\_\_