EAR, NOSE AND THROAT ASSOCIATES

Patient Questionnaire

Name: _____ Date of Birth: _____

Age: _____ Gender: ☐ Male ☐ Female Name of Referring Doctor: _____

What is the main symptom and reason for your appointment? Please list a specific symptom or problem, such as nasal congestion, hoarseness, ear pain, etc.: _____

What other related symptoms do you have? _____

How many days, weeks, months or years have you had these symptoms? _____

How often do you have these symptoms and when do they occur? _____

Is there anything that makes the symptoms better or worse? _____

What treatment, if any, have you already received for these problems and what was the result? _____

_____

_____

SOCIAL HISTORY

Current Occupation: _____

Smoking: ☐ Never Smoked ☐ Previous Smoker (quit _____ years ago)

☐ Currently Smoke _____packs/day for _____ years

☐ Chew Tobacco (_____ years) ☐ Smoke Cigars or Pipe (_____ years)

Alcohol: ☐ Daily ☐ Occasionally ☐ Rare ☐ Never

Caffeine: ☐ Daily ☐ Occasionally ☐ Rare ☐ Never

Please leave space below for physician.

Patient Questionnaire Reviewed By:

_____

Signature of Physician Date

Name: _____ **Date of Birth:** _____

Current Medications (please list all medications, including over-the-counter medications and herbs): _____

_____

Preferred Pharmacy (name and city): _____

Allergies to Medications: _____

Past Medical History: *Please check **YES** or **NO** for every problem listed below.*

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Irregular heartbeat	☐	☐	Thyroid disease	☐	☐
Bleeding disorder	☐	☐	Seizure disorder	☐	☐	Depression	☐	☐
Cancer	☐	☐	Rheumatic fever	☐	☐	Mental illness	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐	High blood pressure	☐	☐
Heart attack	☐	☐	Lung disease	☐	☐	Heart disease	☐	☐
Coronary heart disease	☐	☐	Stroke or TIA	☐	☐	Malignant hyperthermia	☐	☐
Obstructive sleep apnea	☐	☐	Migraine	☐	☐	G.E.R.D.	☐	☐

Do you have any other medical problems? _____

Please list ALL surgeries you have had with dates: _____

Family History: Please list any significant illnesses in your family. _____

Review of Systems: *Please check either **YES** or **NO** for every problem listed below.*

	Yes	No	R	L	Both		Yes	No		Yes	No
Ringing in the ears	☐	☐				Sore throat	☐	☐	Poor sleep	☐	☐
Hearing loss	☐	☐	☐	☐	☐	Trouble swallowing	☐	☐	Daytime sleepiness	☐	☐
Dizziness	☐	☐				Pneumonia	☐	☐	Fatigue	☐	☐
Ear pain	☐	☐				Visual problems	☐	☐	Loud snoring	☐	☐
Loud noise exposure	☐	☐				Abdominal pain	☐	☐	Heart murmur	☐	☐
Sneezing	☐	☐				Numbness/tingling	☐	☐	Excessive bleeding	☐	☐
Nasal congestion	☐	☐				Aspirin sensitivity	☐	☐	Lump in throat	☐	☐
Itchy nose	☐	☐				Indigestion	☐	☐	Excess phlegm	☐	☐
Runny nose	☐	☐				Heartburn/Reflux	☐	☐	Painful swallowing	☐	☐
Allergies/hay fever	☐	☐				Nausea	☐	☐	Jaundice (yellow skin)	☐	☐
Yellow/green mucous	☐	☐				Hoarseness	☐	☐	Headaches	☐	☐
Facial pressure or pain	☐	☐				Cough	☐	☐	Chest pain	☐	☐
Decreased smell	☐	☐				Wheezing	☐	☐	Severe fatigue	☐	☐
Nosebleeds	☐	☐				Shortness of breath	☐	☐	Weight loss	☐	☐

The above information is true and correct to the best of my belief.

_____

Signature of Patient or Guardian Date