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- Pediatric & Adult Otolaryngology
- Head and Neck Surgery

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Patient Name: ________________________ **Chart Number (office use only):** ___________

Reason for Visit: ____

Health Questionnaire

To be completed by the patient, parent, or caregiver. Please print.

Height (in): __________

Weight (lbs): __________

Family History (If you or any blood relative has suffered any of the following, please mark and provide which relative.)

Illness:	Relative:
( ) Epilepsy (Seizures)	____________
( ) Migraine headaches	____________
( ) Mental Illness	____________
( ) Glaucoma	____________
( ) Diabetes	____________
( ) Thyroid goiter	____________
( ) Seasonal allergies	____________
( ) Asthma	____________
( ) Anemia	____________
( ) Bleeds Easily	____________
( ) Osteoporosis	____________
( ) Arthritis	____________
( ) Heart Disease	____________
( ) Stroke	____________
( ) Cancer (list type)	____________
( ) Stroke	____________
( ) High Cholesterol	____________
( ) Alcoholism	____________
( ) Other Substance Abuse	____________
( ) Genetic Disease	____________
( ) High Blood Pressure	____________

Medical History (Check for a current or past problem.)

Respiratory System
( ) Asthma
( ) Emphysema
( ) Other: ____________

Cardiovascular System
( ) Hypertension
( ) High cholesterol
( ) Coronary artery / Heart disease

Endocrine System
( ) Diabetes
( ) Thyroid disease
( ) Other: ____________

Gastrointestinal System
( ) Difficulty swallowing
( ) Ulcer
( ) Hiatal hernia
( ) Gastroesophageal reflux / Heartburn / Indigestion
( ) Other: ____________

Neurologic System
( ) Diabetes
( ) Thyroid disease
( ) Other

Urologic System
( ) Kidney Stones
( ) Prostate problems
( ) Other: ____________

Hematologic System
( ) Anemia
( ) H.I.V.
( ) Leukemia

Otolaryngology
( ) Glaucoma
( ) Malignancies
( ) Hiatal Hernia

Other (please list): ________________________

Current Medications (List all medications that you take. Include those that you take without a prescription, including vitamins and dietary supplements.)

	Name of Medication:	Strength:	Reason for Taking:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(Please attach separate sheet or write on back if more space is required.)

Drug Allergies (List all drug allergies, including the associated reaction. Please attach separate sheet or write on back if more space is required.)

Name of Medication:	What was your reaction?:
1. ______________________	______________________________
2. ______________________	______________________________
3. ______________________	______________________________
4. ______________________	______________________________
5. ______________________	______________________________

Past Medical History (Please list significant past surgeries or major illnesses. Indicate the year of hospitalization and the reason, do not include normal pregnancies)

Year:	Surgery/Illness:	Reason:
________	______________________________	________________
________	______________________________	________________
________	______________________________	________________
________	______________________________	________________
________	______________________________	________________

Lifestyle and Habits

Tobacco use:

( ) No tobacco history

( ) Tobacco history, but no current use

When did you quit? ______________ How long did you smoke for? ____________

( ) Current cigarette use

Packs per day: ____________ How long have you smoked? _________________

( ) Other tobacco products (please list:) _____________________

Current alcohol use:

( ) No alcohol use

( ) Current alcohol use

Number of standard drinks per week: ________

(1 standard drink = 12 oz beer, 4 oz wine, or 1.5 oz spirits)

Current caffeine consumption:

( ) No caffeine consumption

( ) Current caffeine consumption:

Cups of coffee (or equivalent) per day: ________

(1 cup of coffee = 70-140 mg caffeine)

Aspirin use ( ): dose _____ mg; #per day: _____

Regular exercise ( ) _____ times a week of 30 minutes or more

I hereby certify that the information provided above is correct and true to the best of my knowledge.

_____________________________________ Patient's Signature (if 18 or older)

_____________________________________ Parent, Guardian, or Responsible Party Signature

_______/________/_______ Date

_____________________________________ Physician Reviewed

_______/________/_______ Date