Patient Medical Questionnaire (front & back)

Carolina Ear & Hearing Clinic, PC ★

Patient Name:	Date:

1. What is the reason for your visit today?

2. What treatment have you received for this condition?

3. Please list your other health care providers (primary care, ENT, cardiologist, etc.):

How much is your hearing loss affecting your daily life? (circle a number)

Very little 1 2 3 4 5 6 7 8 9 10 Very much

Medical History/Review of Systems

4. How would you rate your general health?

5. The following is a list of common symptoms and health problems. Please review the list and check the box if you are currently experiencing or have ever had/been diagnosed with any of these symptoms and/or health problems.

- ☐ Allergies/Hay Fever
- ☐ Anemia/Bleeding Disorder
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Chronic Lung Disease
- ☐ Bloody Nose
- ☐ Blurry/Double Vision
- ☐ Bowel Irregularity
- ☐ Cancer/Tumors
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Chronic Fatigue Syndrome
- ☐ Daytime Sleepiness
- ☐ Decreased Energy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Ear Infections/Chronic
- ☐ Eye Pain
- ☐ Facial Pain Fevers/Chills
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hoarseness/Voice Problems
- ☐ Immunodeficiency
- ☐ Kidney Disease
- ☐ Meningitis/Encephalitis
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Muscle Aches
- ☐ Muscle/Skeletal Problems
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ Radiation Therapy
- ☐ Ringing in the Ears
- ☐ Runny Nose
- ☐ Seizures/Epilepsy
- ☐ Sinus/Nasal Pain/Disease
- ☐ Skin Problems/Rashes
- ☐ Sore Throat
- ☐ Stroke
- ☐ Syncope/Fainting Spells
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Weight Gain/Loss

6. Please list your previous surgical procedures.

- ☐ Did you experience any difficulty with anesthesia?
- ☐ Did you experience any bleeding problems following surgery?

7. Please list your previous injuries or accidents:
- ☐ To the ear and/or head
- ☐ Noise Exposure
- ☐ Other

8. Are you disabled in any way or have any birth defects?
- ☐ Yes
- ☐ No

If yes, please describe.

9. Are you allergic to any medications?
- ☐ Yes
- ☐ No

If yes, please list and explain your reaction to this medication

10. Are you taking any currently taking any medication that may affect blood clotting (i.e., Coumadin)?
- ☐ Yes
- ☐ No

11. Please list your current medications (or attach a complete list that we may keep). **Please include all prescription and over-the-counter medications, vitamins, herbal supplements, etc.** Use the back of this page if necessary.

Medication Name	Dosage (mg, ml, etc)	Frequency (how often)	Route of Administration

12. Have you received/taken any of the following:
- ☐ Prolonged use of IV antibiotics (given by vein)
- ☐ Chemotherapy agents for cancer
- ☐ High doses of aspirin (more than 8 per day)
- ☐ Quinine for malaria
- ☐ Diuretics (water pills)
- ☐ Cortisone

If yes to any of these, please explain usage.

13. A. Have you received any alternative treatments or medical care (acupuncture, chiropractic, etc.)?
- ☐ Yes
- ☐ No

If yes, please specify type of care and for what reason.

13 B. Have you received your influenza/pneumococcal vaccination this year?
- ☐ Yes
- ☐ No

14. Do you or have you had any other medical problems not listed above:
- ☐ Yes
- ☐ No

If yes, please give details.

Family History

15. Do any of your family members have any of the following conditions?

☐ Allergies	☐ Cancer	☐ Heart Disease
☐ Asthma	☐ Cystic Fibrosis	☐ Immunodeficiency
☐ Anemia/Bleeding Disorder	☐ Ear Problems/Hearing Loss	☐ Other

Social History

16. What is your current or previous occupation?

17. Do you smoke?
- ☐ Yes
- ☐ No
- ☐ Previously

If yes, how much?
If previously, when did you quit?

18. Describe your diet:
- ☐ Regular
- ☐ Special

Please explain any special diet.

19. Do you drink alcoholic beverages?
- ☐ Yes
- ☐ No

If yes, what type and how much?

20. Do you exercise?
- ☐ Yes
- ☐ No

If yes, what type and how often?

21. Do you drink caffeine (coffee, tea, soda)?
- ☐ Yes
- ☐ No

If yes, what type and how much?

22. Have you had any recent changes in your home or work environment?
- ☐ Yes
- ☐ No

If yes, please give details.