

Patient Medical Questionnaire (front & back)



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.):	

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.		
<input type="checkbox"/> Allergies/Hay Fever <input type="checkbox"/> Anemia/Bleeding Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/Chronic Lung Disease <input type="checkbox"/> Bloody Nose <input type="checkbox"/> Blurry/Double Vision <input type="checkbox"/> Bowel Irregularity <input type="checkbox"/> Cancer/Tumors <input type="checkbox"/> Cataracts <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Decreased Energy <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Ear Infections/Chronic	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Facial Pain Fevers/Chills <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Gastritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hoarseness/Voice Problems <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Meningitis/Encephalitis <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Muscle/Skeletal Problems	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Numbness <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> Runny Nose <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Sinus/Nasal Pain/Disease <input type="checkbox"/> Skin Problems/Rashes <input type="checkbox"/> Sore Throat <input type="checkbox"/> Stroke <input type="checkbox"/> Syncope/Fainting Spells <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Ulcers <input type="checkbox"/> Weight Gain/Loss
6. Please list your previous surgical procedures.		
<input type="checkbox"/> Did you experience any difficulty with anesthesia? <input type="checkbox"/> Did you experience any bleeding problems following surgery?		
7. Please list your previous injuries or accidents:	8. Are you disabled in any way or have any birth defects?	
<input type="checkbox"/> To the ear and/or head <input type="checkbox"/> Noise Exposure <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.	
9. Are you allergic to any medications?		
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list and explain your reaction to this medication		

<p>10. 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.</p>	
<p>11. Have you received/taken any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prolonged use of IV antibiotics (given by vein) <input type="checkbox"/> Chemotherapy agents for cancer <input type="checkbox"/> High doses of aspirin (more than 8 per day) <input type="checkbox"/> Quinine for malaria <input type="checkbox"/> Diuretics (water pills) <input type="checkbox"/> Cortisone <p>If yes to any of these, please explain usage.</p>	<p>12. Have you received any alternative treatments or medical care (acupuncture, chiropractic, etc.)?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, please specify type of care and for what reason.</p>
<p>13. Do you or have you had any other medical problems not listed above:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, please give details.</p>	

Family History

<p>14. Do any of your family members have any of the following conditions?</p>		
<ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia/Bleeding Disorder 	<ul style="list-style-type: none"> <input type="checkbox"/> Cancer <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Ear Problems/Hearing Loss 	<ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Other

Social History

<p>15. What is your current or previous occupation?</p>	
<p>16. Do you smoke?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <p>If yes, how much? If previously, when did you quit?</p>	<p>17. Describe your diet:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Regular <input type="checkbox"/> Special <p>Please explain any special diet.</p>
<p>18. Do you drink alcoholic beverages?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, what type and how much?</p>	<p>19. Do you exercise?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, what type and how often?</p>
<p>20. Do you drink caffeine (coffee, tea, soda)?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, what type and how much?</p>	<p>21. Have you had any recent changes in your home or work environment?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, please give details.</p>