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Division of Otolaryngology

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New Adult Patient Questionnaire

Patient Name: ___________________________________ Date: ________ Age: ________

Referred by: ☐ Physician: ______________________________ ________________________
(Specialty)

☐ TV ad ☐ Internet ☐ Another patient ☐ Other: _______________________

Reason for today's visit:

____

____

PAST MEDICAL / SURGICAL HISTORY

Have you ever had any of the following medical problems?

☐ High blood pressure ☐ Stroke ☐ Acid regurgitation (GERD) ☐ Tuberculosis
☐ Heart attack ☐ Diabetes ☐ Cancer (type): _________ ☐ Bleeding disorder
☐ Asthma ☐ Hepatitis ☐ Psychiatric treatment ☐ Blood clot (DVT / PE)
☐ COPD / emphysema ☐ Prostate problems ☐ Arthritis (specify site(s)): _____________________

List any other major illnesses and/or injuries, **other than** the reason for today's visit:

____

____

Surgeries/Hospitalizations	Year	Complications

Have you ever had a problem with anesthesia? ☐ No ☐ Yes (describe) ___________________

____

MEDICATIONS

Current Medications	Dose	Frequency

If not already listed above, do you regularly take any blood thinners? (circle any)
Aspirin Ibuprofen (Motrin, Aleve, etc.) Coumadin Plavix Other ______

Have you taken oral steroids (ex. prednisone, medrol) within the past year? Yes No

ALLERGIES

Allergies to Medications: ☐ Yes ☐ No
If yes, please list including type of reaction.

Any allergy to medical tape, iodine, or latex? ☐ Yes (describe) ______________________ ☐ No

Have you ever had Allergy Skin testing? ☐ Yes ☐ No
If "yes" what allergies were detected? ____
Have you ever had Allergy Shots (Immunotherapy)? ☐ Yes ☐ No If "yes" did it help? ☐ Yes ☐ No

SOCIAL HISTORY

Current occupation (or most recent, if not currently working): ______________________________________
Occupational Status: ☐ Employed ☐ Homemaker ☐ Unemployed ☐ Retired (year) _____
☐ Student (where): _____________________________ ☐ Disabled (reason) _________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Who lives at home with you? ____
Do you have children? ☐ Yes (Please list their ages if under 18) _________________ ☐ No

Do you currently smoke? ☐ Yes ☐ No Have you ever smoked in the past? ☐ Yes ☐ No
At what age did you start smoking? _____ At what age did you stop smoking? ______
Products used: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing tobacco ☐ Marijuana
How often (e.g. # of packs per day)? ____
Any exposure to second-hand smoke? ☐ Yes ☐ No Describe: ____________________

Do you drink alcoholic beverages? ☐ Yes ☐ No If so, how often? _________________________
Any history of alcohol abuse? ☐ Yes ☐ No If so, give approximate dates ______________

FAMILY HISTORY

Mother's age: ____ ☐ Alive ☐ Deceased - cause of death ________________________

Father's age: ____ ☐ Alive ☐ Deceased - cause of death ________________________

Any significant diseases that run in the family? (please specify which relative)

☐ Allergy Asthma ☐ Bleeding disorder ☐ Cystic Fibrosis ☐ Heart Disease
☐ Immunodeficiency ☐ Cancer (specify type): _____________ ☐ Other: __________

____

REVIEW OF SYSTEMS

Please check all symptoms which you are currently experiencing or have experienced in the past month:

CONSTITUTIONAL

☐ Unintentional weight loss: ____ pounds in the past ___ weeks ☐ Fever, chills

EYES:

☐ Double vision
☐ Loss of vision
☐ Eye pain

ENT:

☐ Hearing loss
☐ Ringing in ears
☐ Ear pain
☐ Ear drainage
☐ Nose drainage
☐ Nasal congestion
☐ Facial pain
☐ Sore mouth/throat
☐ Swallowing pain
☐ Voice change / loss
☐ Throat clearing
☐ Hoarseness

CARDIOVASCULAR:

☐ Chest pain
☐ Irregular heartbeat
☐ Leg pain during walking
☐ Swelling of legs or feet

PULMONARY:

☐ Shortness of breath attack
☐ Wheezing
☐ Coughing up blood
☐ Chronic cough

GASTROINTESTINAL:

☐ Heartburn
☐ Difficulty swallowing liquids
☐ Difficulty swallowing solids
☐ Nausea / vomiting (circle which)

GENITOURINARY:

☐ Blood in urine
☐ Pain during urination
☐ Difficulty urinating

MUSCULOSKELETAL:

☐ Neck pain
☐ Back pain
☐ Joint pain

PSYCHIATRIC:

☐ Depression
☐ Nervous / anxious
☐ Substance abuse

NEUROLOGICAL:

☐ Headaches
☐ Memory Loss
☐ Speech problems
☐ Numbness
☐ Seizure
☐ Tingling
☐ Weakness
☐ Dizziness

The above information is accurate to the best of my knowledge.

X ________________________________ ________________________

Patient Signature Date

For Physician Use Only:

I have reviewed the above information with the patient.

________________________________ ________________________

Physician Name & Signature Date