Medical History Questionnaire / ENT **Referring Provider:**

List reason(s) for visit and duration of problem:	**Vitals**
	BP:
	Pulse:
	Temp:

Past Medical History

Allergies:

Current prescription medications: Reviewed from chart and patient.

Over-the-counter-medications:

Active Medical Problems: Reviewed from chart and patient.

Past Medical History: Reviewed from chart and patient.

Surgical History: Reviewed from chart and patient.

Social History

Marital Status [circle one]: S M D S W Occupation:

Do you smoke?	☐ Yes	If yes, number of years: How many packs per day:	☐ No	☐ Quit Quit date: / /

☐ I have | ☐ I have never used Illicit drugs. Specify:

Do you drink alcohol now?	☐ Yes	How many beers/drinks per day
	☐ No	☐ Quit → Quit date: / /

Family History: Does anyone in your family.

Head /Neck Cancer/Brain Tumor:		*Relationship:*
Thyroid Cancer:		*Relationship:*
Skin Cancer:		*Relationship:*
Other:		

APPT. LABEL (REQUIRED ON PAGE 1 ONLY)

Medical History Questionnaire

SYSTEM REVIEW: Check only symptoms that you have had in the last 3 months. If not applicable, please check N/A.

General Health

- ☐ Unexplained Weight loss
- ☐ Appetite change
- ☐ Fever
- ☐ Chills
- ☐ Extreme Fatigue
- ☐ N/A

Eyes:

- ☐ Loss of vision
- ☐ Double vision
- ☐ Pain
- ☐ Discharge
- ☐ Itching
- ☐ N/A

Ears, Nose, Mouth, Throat (problems other than current visit)

- ☐ Hearing loss
- ☐ Ear ringing
- ☐ Ear ache
- ☐ Ear drainage
- ☐ Dizziness
- ☐ Nasal discharge
- ☐ Sneezing
- ☐ Stuffy nose
- ☐ Nose bleed
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Sore throat
- ☐ Facial pain/paralysis
- ☐ Hoarseness
- ☐ Lump in neck
- ☐ Mouth growth/ulcer/bleed
- ☐ Snoring
- ☐ N/A

Heart, Veins, Arteries (Cardiovascular):

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ N/A

Respiratory:

- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ N/A

Stomach, Intestines (Gastrointestinal):

- ☐ Indigestion / heartburn
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ N/A

Bones, Joints, Muscles (Musculoskeletal):

- ☐ Joint pain/ stiffness
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle spasms
- ☐ N/A

Skin (Integumentary)/**Breast**:

- ☐ New skin growths
- ☐ Rash
- ☐ Jaundice
- ☐ N/A

Neurological:

- ☐ Headaches
- ☐ Blackouts
- ☐ Seizures
- ☐ Paralysis
- ☐ Tingling/numbness
- ☐ N/A

Psychiatric:

- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ N/A

Endocrine:

- ☐ Thyroid trouble
- ☐ Heat/cold tolerance
- ☐ Excessive thirst, hunger, urination
- ☐ N/A

Genitourinary/Gynocology:

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Pregnant currently
- ☐ Menstruating
- ☐ N/A

Hematologic:

- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ N/A

Discussions:

Patient Signature Date

APPT. LABEL (REQUIRED ON PAGE 1 ONLY)