ENT New Patient Questionnaire - Adult

DATE: ______________________

☐ Male ☐ Female
☐ Other (specify: ____________)

NAME: ____ **Marital Status:** _________________________

What is the reason for your visit? ____

Past Medical History/Past Surgical History

☐ Asthma
☐ Fibromyalgia
☐ Liver disease
☐ Diabetes
☐ Seizures
☐ Heart disease
☐ High blood pressure
☐ Osteoporosis
☐ Kidney disease
☐ Hearing loss/Deafness at birth
☐ Environmental allergies

☐ Stroke
☐ Depression
☐ Anxiety
☐ Other mental health conditions (specify: __________)
☐ Cancer (type(s) ______________________________)
☐ Bleeding disorder (type _______________________)
☐ Immune deficiency
☐ Gastritis/Ulcers/GERD
☐ Low/High Thyroid
☐ Autoimmune disease
☐ Hepatitis (type ___)
☐ Other: ____________________________________

Please list any previous hospitalizations or surgeries

Date	Reason/Procedure	Hospital

Family History

☐ Asthma
☐ Fibromyalgia
☐ Liver disease
☐ Diabetes
☐ Seizures
☐ Heart disease
☐ High blood pressure
☐ Osteoporosis
☐ Kidney disease
☐ Hearing loss/Deafness at birth
☐ Environmental allergies

☐ Stroke
☐ Depression
☐ Anxiety
☐ Other mental health conditions (specify: ___________)
☐ Cancer (type(s): __________________________)
☐ Bleeding disorders (type(s): _____________________)
☐ Immune deficiency
☐ Gastritis/Ulcers/GERD
☐ Low/High Thyroid
☐ Autoimmune disease (Lupus, Rheumatoid arthritis, Crohn's dz, etc)
☐ Complications from anesthesia or sudden unexplained death

Social History

Do you presently smoke? **Y / N** (circle one). If so, how much? _____ # packs per day, ______ # of years
Have you ever smoked? **Y / N** (circle one). If so, how much? _____ # packs per day, ______ # of years.
What year did you quit? ________
Do you drink alcohol? **Y / N** (circle one). If yes, # drinks per day: ______________
Have you ever used any other addictive substances? Name: ____

Preferred Pharmacy: ____

Current Medications/Vitamins/Supplements

Name	Dose	Frequency

Allergies No known drug allergies, check here ________

☐ Environmental (specify: ______________________________)

☐ Latex

☐ Medications

Medications	Reaction

Review of Symptoms: Please mark (X) in the available blanks if any of the following apply to you **NOW** or in the **PAST**:

Now	Past	**Head, Eyes, Ears, Nose, Throat**
[ ]	[ ]	Noise exposure
[ ]	[ ]	Head injury or concussion
[ ]	[ ]	Draining or painful ears
[ ]	[ ]	Hearing loss
[ ]	[ ]	Ringing in the ears
[ ]	[ ]	Dizziness or loss of balance
[ ]	[ ]	Chronic facial pain or headaches
[ ]	[ ]	Chronic nasal congestion or drainage
[ ]	[ ]	Frequent nose bleeds
[ ]	[ ]	Difficulty swallowing
[ ]	[ ]	Hoarseness
[ ]	[ ]	Throat pain
[ ]	[ ]	Jaw pain
[ ]	[ ]	Chronic cough
[ ]	[ ]	Tooth pain/Loose teeth/Bite problems
[ ]	[ ]	Snoring/Sleep Apnea
[ ]	[ ]	Double vision/Eye pain/Change in vision

Now	Past	**General**
[ ]	[ ]	Unexplained fever/Night sweats
[ ]	[ ]	Unexplained weight loss or pain
[ ]	[ ]	Joint pains and swelling

Now	Past	**Lungs**
[ ]	[ ]	Coughing up blood
[ ]	[ ]	Persistent wheezing/Asthma
[ ]	[ ]	Shortness of breath
[ ]	[ ]	Abnormal chest x-ray
[ ]	[ ]	History of TB

Now	Past	**Heart - Circulation**
[ ]	[ ]	Chest pain
[ ]	[ ]	Heart palpitations/Heart rhythm disturbance
[ ]	[ ]	Leg vein trouble/Leg pain when walking
[ ]	[ ]	Ankle swelling

Now	Past	**Psychiatric/Mental Health**
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety
[ ]	[ ]	Post-traumatic stress disorder (PTSD)

Now	Past	**Urinary**
[ ]	[ ]	Frequent urination/Trouble holding urine
[ ]	[ ]	Trouble starting urine
[ ]	[ ]	Urinate more than two times a night
[ ]	[ ]	Stress or urge incontinence

Now	Past	**Nervous System**
[ ]	[ ]	Fainting spells (blackouts)
[ ]	[ ]	Convulsions (seizures, fits, epilepsy)
[ ]	[ ]	Tremor (shaking, trembling)
[ ]	[ ]	Paralysis (or weakness of any body part)
[ ]	[ ]	Numbness (body parts "go to sleep")

Now	Past	**Females**
[ ]		Pregnant (Any possibiity?)

Now	Past	**Endocrine System**
[ ]	[ ]	Dry skin
[ ]	[ ]	Hot/Cold intolerance
[ ]	[ ]	Thirst
[ ]	[ ]	Appetite change
[ ]	[ ]	Rapid weight gain/loss
[ ]	[ ]	Excessive fatigue

Now	Past	**Allergy/Immune System**
[ ]	[ ]	Hives or chronic itching
[ ]	[ ]	Previous allergy workup
[ ]	[ ]	Hay fever

Now	Past	**Heme/Lymph System**
[ ]	[ ]	Easy bruising
[ ]	[ ]	Bleeding problems
[ ]	[ ]	Taking blood thinners
[ ]	[ ]	Enlarged glands

Now	Past	**Stomach - Gastrointestinal**
[ ]	[ ]	Heartburn/Regurgitation/Indigestion
[ ]	[ ]	Frequent or severe stomach pain
[ ]	[ ]	Frequent or severe vomiting
[ ]	[ ]	Vomiting blood