UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Otolaryngology

Health History Questionnaire

Pt. Name: _____

Address: _____

_____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX: _____

DOS: _____

Age: _____ Name of Referring Physician: _____

Address of Referring Physician: _____

Fax Number of Referring Physician: _____

Family Physician (if different): _____

What symptoms led to your visit today? _____

Do you have, or have you ever had any of the following (please mark if YES):

◯ High blood pressure	◯ Asthma	◯ Diabetes	◯ Memory lapses
◯ Heart trouble	◯ Shortness of breath	◯ Thyroid problems	◯ Epilepsy
◯ Chest pain	◯ Bronchitis	◯ Urinary problems	◯ IV drug use
◯ Heart burn	◯ Pneumonia	◯ Prostate problems	◯ Drug addiction
◯ Stomach ulcer	◯ Tuberculosis	◯ Kidney disease	◯ Alcoholism
◯ Duodenal ulcer	◯ Chronic lung disease	◯ Blood disorder	◯ AIDS/HIV
◯ Intestinal bleeding	◯ Cancer	◯ Blood transfusion	◯ Venereal disease
◯ Bowel disorder	◯ Eye disease	◯ Anemia	◯ Rheumatic fever
◯ Liver problems	◯ Migraine headache	◯ Prolonged bleeding	◯ Psychiatric treatment
◯ Hepatitis or jaundice	◯ Arthritis	◯ Stroke	◯ Illegal drug use

◯ Hearing problems? Which ear? ◯ Right ◯ Left ◯ Both How long? _____

Was your hearing loss ◯ Gradual ◯ Sudden ◯ Varying

◯ Hear noises in your head? Which ear: ◯ Right ◯ Left ◯ Both When did it start?_____ How often?_____

Which describes the noise? ◯ High pitch ringing ◯ Crickets ◯ Roaring ◯ Pulsating

◯ Ever been exposed to noise for long periods of time?

◯ Ever been tested for allergies?

◯ Ever been on allergy shots?

◯ Are you currently on allergy shots?

MEDICAL PROBLEMS (list other current or previous medical conditions): _____

_____

_____

SURGERY (list previous operations and dates):

◯ Tonsils _____ ◯ Appendix _____ ◯ C-section _____ ◯ Hysterectomy _____

◯ Other _____

PLEASE COMPLETE QUESTIONS ON THE BACK SIDE OF THIS SHEET

Form # OTA/HHQ-001 / 01.02 (Rev. 07.07)

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HOSPITALIZATIONS (list reasons and dates you have been a patient in the hospital, OTHER THAN FOR SURGERY):

_____

MEDICATIONS (list any medications yo u are currently taking):

_____

_____

Do you have any DRUG REACTIONS or DRUG ALLERGIES: ◯ No ◯ Yes _____

If yes, what type of reactions do you have? _____

Do you have any risk factors for AIDS/HIV? ◯ No ◯ Yes

(e.g., blood transfusion, occupations, IV drugs, sexual contact)

FAMILY HISTORY

Father: ◯ Alive ◯ Dead Medical problems: _____

Cause of death: _____

Mother: ◯ Alive ◯ Dead Medical problems: _____

Cause of death: _____

Siblings: ◯ Alive ◯ Dead Medical problems: _____

Cause of death: _____

Other medical problems in family: ◯ Cancer ◯ Diabetes ◯ Heart attack ◯ Stroke ◯ Hearing problems

◯ Allergy (hay fever, eczema, asthma) ◯ Other (list) _____

SOCIAL HISTORY

Occupation: _____ Marital status: ◯ S ◯ M ◯ D ◯ W

Cigarettes: ◯ Never smoked ◯ Currently smoking ◯ Quit: How many years ago? _____

If you ever smoked? How many packs per day? _____ How many years have you, or did you smoke? _____

Other tobacco: ◯ Never used ◯ Pipe ◯ Cigar ◯ Dip snuff ◯ Chew tobacco ◯ Currently using

◯ Quit: How many years ago? _____ How much/day: _____ How many years: _____

Are you exposed to smoke at ◯ home or ◯ work?

Alcohol: ◯ Do not use ◯ Never have used ◯ Quit: How many years ago? _____

Do you use: ◯ Beer ◯ Wine ◯ Liquor Amount: _____ per: ◯ Week ◯ Month

What is your height: _____ Weight: _____

Completed by: _____ Date: _____

FOR OFFICE USE ONLY

BP _____ P _____ R _____ WT _____ (lbs)

_____

I have read and reviewed these results with the patient and/or responsible party.

Physician's Signature: _____ Date: _____