Wilmington Ear Nose & Throat Associates, P.A.

Health History Questionnaire

Patient Name: _____ DOB: _____

Reason for Today's Visit: _____

Referring Physician: _____ Primary Care Physician:_____

PAST MEDICAL HISTORY: (Please check **ALL** that apply)
Do you have or have been treated for any of the following?

☐ AIDS/HIV	☐ Bleeding Disorder	☐ Arthritis	☐ Asthma
☐ Depression	☐ Heart Disease/Attack	☐ Sickle Cell	☐ Diabetes
☐ Liver Disease	☐ Tuberculosis (TB)	☐ Seizures	☐ Meningitis
☐ Kidney Disease	☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Stroke
☐ Thyroid Disease	☐ Cancer (Type: _____)	☐ Cataracts	☐ Hypertension
☐ Stomach Ulcers	☐ Transplant (Type: _____)	☐ Ear Disease	☐ Sleep Apnea
☐ Hepatitis	☐ Other: _____	☐ Other: _____	☐ _____

SURGERIES: (Please List)

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS: (INCLUDING VITAMINS, HERBS, AND OVER-THE COUNTER)

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
Medication	Dosage	Medication	Dosage
_____	_____	_____	_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO
If YES, please list the medication(s) and describe the reaction:

Name	Reaction	Name	Reaction
_____	_____	_____	_____
Name	Reaction	Name	Reaction
_____	_____	_____	_____

FAMILY HISTORY: (Please check **ALL** that apply to your ***family members***)

☐ Hearing Loss	☐ Cystic Fibrosis	☐ Sinus Disease	☐ Allergy/Asthma	☐ Stroke
☐ Heart Disease	☐ Hypertension	☐ Cancer	☐ Bleeding Disorder	☐ _____

*****PLEASE CONTINUE ON PAGE 2*****

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SOCIAL HISTORY & HEALTH BEHAVIORS

What is your occupation? _____

Have you ever smoked cigarettes, cigars or a pipe? ☐ YES ☐ NO

If you have stopped smoking, when did you quit? _____

How long did you smoke? _____ years

If you still smoke, how much do you smoke per day? _____ packs per day

Do you drink alcohol? ☐ YES ☐ NO

If YES, how much do you drink per week? _____

Have you ever used any addictive substances or drugs? ☐ YES ☐ NO

If YES, list the substances and when you last used them. _____ _____ _____

REVIEW OF SYSTEMS: Check **ALL** of the following that you have now

GENERAL

- ☐ Nausea
- ☐ Recent Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever / Chills / Night Sweats

SLEEP DISTURBANCE

- ☐ Loud Snoring
- ☐ Excessive Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Breathing Stops During Sleep
- ☐ Wake up Feeling Tired

CARDIOPULMONARY

- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest Tightness

NERVOUS

- ☐ Numbness
- ☐ Tingling
- ☐ Fainting
- ☐ Weakness

PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Depression

ABDOMINAL

- ☐ Diarrhea/Constipation
- ☐ Abdominal Pain

EARS

- ☐ Ringing
- ☐ Hearing Loss
- ☐ Dizziness / Vertigo
- ☐ Pain
- ☐ Fullness / Pressure
- ☐ Drainage

MOUTH / THROAT

- ☐ Soreness
- ☐ Ulcers
- ☐ Difficulty Swallowing
- ☐ Lumps in Neck
- ☐ Painful Swallowing
- ☐ Hoarseness
- ☐ Choking

ENDOCRINE

- ☐ Temperature Intolerance
- ☐ Excessive Thirst

EYES

- ☐ Change in Vision
- ☐ Clouded Vision
- ☐ Dry Eyes
- ☐ Double Vision

GASTROINTESTINE

- ☐ Indigestion
- ☐ Heartburn
- ☐ Vomiting
- ☐ Change in Stool