Ear, Nose, Throat & Facial Plastic Surgery Associates
Medical Questionnaire

Patient Name: ___________________________________ **Date:** ________
Date of Birth:____________________________________ **Age:** ________
Referring Physician: ______________________________
Primary Care Physician: __________________________

Reason for today's visit: ____
When did you first notice the problem? ______________________________________
Have you been treated or used anything for this problem? _____________________

Please list any current medical problems:

_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

Please list any prior major illness and/or injuries:

_________________________ _________________________
_________________________ _________________________

Surgeries/Hospitalizations:

Operation/Reason for Hospitalization	Year	Hospital	Problems?
_________________________	____	_________	____________
_________________________	____	_________	____________
_________________________	____	_________	____________

Have you had surgery on your ____ears ____nose/sinuses _____throat or ____neck?

Have you had any recent dental procedures or infections? Yes___ No___
Have you had TMJ problems (Temporomandibular Joint)? Yes____ No____

Have you had any problems with anesthesia? Yes___ No___ Explain: __________
Any family members with problems with anesthesia? Yes___ No____

Do you have any allergies to ___tape, ___iodine, ___latex, ________fish/shellfish?

Medications

Do you have any allergies to medications? If YES, please list: _______________
Are you taking Aspirin, Ibuprofen, or other blood thinners (ex. Plavix, coumadin/warfarin)? No:____Yes, I am taking:_____________________
List all current medications (include dose and frequency):

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Family History: Does any member of your family have cancer, diabetes, heart disease, respiratory disease or other illnesses? Please include deceased family members.

Relationship	Medical Condition
________________	____________________________________
________________	____________________________________
________________	____________________________________

Occupation: ____

Marital Status: Single____ Married____ Divorced____ Widowed______

Do you have children? Yes___ No____ How many? ___________________

Do you live alone? Yes____No____ Who lives with you? ________________

For women: Are you pregnant or considering conceiving? ________________

Are you taking birth control pills? Yes___ No____

Do you smoke?

_____ Yes, I have smoked ____ packs of cigarettes per day for ___ years.

_____ No, I have never smoked.

_____ No, I quit _____ years ago. I was smoking ____ packs per day for ___ years.

Do you chew tobacco? Yes____ No____

Do you drink alcohol?

_____Yes (please state amount and type of drink).____________________________

_____ Never

_____ No, I stopped __ years ago. At that time, I drank __rarely __moderately __heavy.

Do you use recreational drugs? No___Yes___ If yes, please state type:___________

Have you ever used cocaine in your nose? Yes____ No____

Review of Systems: Are you currently or have you had problems with any of the following?

Constitutional	Circle One		Use this side for explanations or conditions not listed
Fever	Yes	No	
Night sweats	Yes	No	
Decreased appetite	Yes	No	
Weight Loss	Yes	No	
Eyes			
Glasses	Yes	No	
Glaucoma	Yes	No	
Cataracts	Yes	No	
Ear			
Hearing Loss	Yes	No	
Ear ringing/tinnitus	Yes	No	
Dizziness	Yes	No	
Vertigo	Yes	No	
Ear Infections	Yes	No	
Ear drainage	Yes	No	
Nose			
Nasal polyps	Yes	No	
Problems with smell	Yes	No	
Broken Nose	Yes	No	
Nose Bleeds	Yes	No	
Sinus Problems	Yes	No	
Throat			
Sore Throat/Tonsillitis	Yes	No	
Hoarse or irregular voice	Yes	No	
Difficulty swallowing	Yes	No	
Pain	Yes	No	
Lump or bump	Yes	No	
Cardiovascular			
Chest pain or angina	Yes	No	

	High Blood Pressure	Yes	No
	Irregular Heart Beat	Yes	No
	High Cholesterol	Yes	No
	Heart Valve	Yes	No
	Swelling of hands/feet	Yes	No
Respiratory			
	Asthma	Yes	No
	Emphysema/Bronchitis	Yes	No
	Shortness of Breath	Yes	No
	Chronic Cough	Yes	No
	Tuberculosis	Yes	No
	Snoring	Yes	No
Gastrointestinal			
	Nausea/Vomiting	Yes	No
	Liver Disease/Hepatitis	Yes	No
	Ulcers or Gastritis	Yes	No
	Acid Reflux/Heartburn	Yes	No
Genitourinary			
	Renal Failure	Yes	No
	Prostate Cancer	Yes	No
	Uterine/Cervical Cancer	Yes	No
Musculoskeletal			
	Arm or Leg Weakness	Yes	No
	Arthritis	Yes	No
	Broken Bones	Yes	No
Integumentary			
	Rash	Yes	No
	Skin Disease	Yes	No
	Nipple Discharge	Yes	No
Neurological			
	Head Injury	Yes	No
	Headache/Migraine	Yes	No
	Seizures	Yes	No
	Double or Blurry Vision	Yes	No
	Facial Weakness	Yes	No
	Stroke	Yes	No
Endocrine			
	Diabetes	Yes	No
	Thyroid Disease	Yes	No
	Menopause	Yes	No
Hematologic			
	Anemia	Yes	No
	Bleeding Disorder	Yes	No
Sexually Transmitted Disease			
	Herpes	Yes	No
	Syphilis	Yes	No
	HIV	Yes	No
	Known intimate contact with HIV carrier?	Yes	No
	Multiple sexual partners	Yes	No
	Anal Intercourse	Yes	No
Psychiatric			
	Anxiety	Yes	No
	Depression	Yes	No
	Panic Attacks	Yes	No
Allergies			
	Food Allergies	Yes	No
	Nasal/Hay fever	Yes	No

Thank you for taking the time to fill out this questionnaire!

I believe that the above information is correct to the best of my knowledge:
Patient Signature: ____________________________________ Date: ___________

I have reviewed the above information with the patient.
Physician signature: __________________________________ Date: ____________