

Wilmington Ear, Nose & Throat
NEW PATIENT QUESTIONNAIRE

Patient Name: _____

DOB: _____

Reason for Today's Visit: _____

Referring Physician: _____ Primary Care Physician: _____

PAST MEDICAL HISTORY: (Check all that apply)

Do you have or have you been treated for any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart disease/attack | <input type="checkbox"/> depression |
| <input type="checkbox"/> tuberculosis (TB) | <input type="checkbox"/> kidney disease | <input type="checkbox"/> sickle cell |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> seizures | <input type="checkbox"/> meningitis | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> cataracts |
| <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> cancer (type: _____) | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> ear disease | <input type="checkbox"/> transplant (type: _____) | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> Other: _____ | |

SURGERIES: (please list)

Date	Reason
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS: (Including vitamins, herbs, and over-the-counter)

Name and dosage			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any ALLERGIES TO MEDICATIONS? Yes No

If so, please list the medication and describe the reaction.

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

- | | | |
|---|--|--|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> cystic fibrosis | <input type="checkbox"/> sinus disease |
| <input type="checkbox"/> allergy/asthma | <input type="checkbox"/> stroke | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> cancer |

SOCIAL HISTORY AND HEALTH BEHAVIORS

What is your occupation? _____

Have you ever smoked cigarettes, cigars or pipes? 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 so, 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 any of the following that you have now or have had

		<u>GENERAL</u>			<u>EARS</u>
Now	Past	nausea	Now	Past	ringing
—	—	recent weight loss/gain	—	—	hearing loss
—	—	fatigue	—	—	dizziness/vertigo
—	—	fever/chills/night sweats	—	—	pain
			—	—	fullness/pressure
			—	—	drainage
Now	Past	<u>SLEEP DISTURBANCES</u>	Now	Past	<u>MOUTH/THROAT</u>
—	—	loud snoring	—	—	soreness
—	—	excessive sleepiness	—	—	ulcers
—	—	difficulty falling asleep	—	—	difficulty swallowing
—	—	breathing stops during sleep	—	—	lumps in neck
—	—	wake up feeling tired	—	—	painful swallowing
			—	—	hoarseness
			—	—	choking
Now	Past	<u>CARDIOPULMONARY</u>	Now	Past	<u>Endocrine</u>
—	—	heart murmur	—	—	temp intolerance
—	—	palpitations	—	—	excessive thirst
—	—	chest pain			
—	—	shortness of breath	Now	Past	<u>EYES</u>
—	—	wheezing	—	—	change in vision
—	—	chest tightness	—	—	clouded vision
			—	—	dry eyes
			—	—	double vision
Now	Past	<u>NERVOUS</u>	Now	Past	<u>GASTROINTESTINE</u>
—	—	numbness	—	—	indigestion
—	—	tingling	—	—	heartburn
—	—	fainting	—	—	vomiting
—	—	weakness	—	—	change in stools
Now	Past	<u>PSYCHOLOGICAL</u>			
—	—	anxiety			
—	—	depression			
Now	Past	<u>ABDOMINAL</u>			
—	—	diarrhea/constipation			
—	—	abdominal pain			

Reviewed by: _____