Otolaryngology–Head and Neck Surgery • **Initial Visit Questionnaire**

Name: _____ **DOB:**_____
Gender (circle) M F
Did a doctor refer you to us? [ ] Yes [ ] No

Referring doctor's name:_____
Doctor's address:_____
_____
Doctor's fax number: (_____) _____
Doctor's phone number: (_____) _____

Reason for visit:_____
How long have you had this problem? _____
Have you been treated for this in the past? If yes please explain:_____
_____

PAST MEDICAL HISTORY

List all medical problems you have had (like high blood pressure, diabetes, cancer, asthma, etc):
_____

Please list your medications (more space on the last page):_____
_____

Do you have any allergies to any medications? If so, what reaction did you have?: _____
_____

Please list any surgical procedures you have had:_____
_____

Any diseases or conditions that run in your family?_____
_____

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SOCIAL HISTORY

1. Do you smoke currently? [ ] No [ ] Yes How many packs per day?_____
   Quit date: _____
2. How many years have/did you smoke? _____
3. How many alcoholic drinks do you have per week?_____
4. Was there ever a time when you consistently drank more than one drink every day?
   [ ] No [ ] Yes
5. If you are working, what do you do for work?_____
6. Do you live with others? [ ] No [ ] Yes
   Who? _____

REVIEW OF SYSTEMS

Please CIRCLE any of the symptoms below if you have experienced them in the last month:

General	Fatigue Fever Night sweats Weight gain Weight loss
Eyes	Blurred vision Double vision Eye pain Irritation from light
Ears	Pain Hearing loss Ringing Dizziness Imbalance Clogged feeling
Nose	Runny nose Stuffy nose Bloody nose Post nasal drainage Snoring Sinusitis Altered sense of smell
Throat	Hoarseness/voice change Sore throat Difficulty swallowing
Allergy	Hives Postnasal drip Nasal congestion Itchy eyes Sneezing Recurrent infection Headache
Lungs	Coughing up blood Pain with breathing Shortness of breath Wheezing Cough
Heart	Chest pain Irregular heartbeat
GI	Abdominal pain Increased appetite Decreased appetite Blood in stool Bowel problems Canker sore Diarrhea Heartburn
GU	Difficulty with urination Frequent urination
Neuro	Clumsiness Convulsions Headache Memory problems Numbness Tingling sensation Weakness
Muscular	Back pain Leg cramping Arthritis Neck pain Teeth grinding
Skin	Skin growths/moles Ulcers Slow healing wounds Dry skin Rash
Endocrine	Hair growth Feeling hot Feeling cold Irregular periods
Heme	Anemia Bruise or bleed easily Joint pain Lymph node swelling
Psych	Depression Hallucinations Mood changes Sleep disturbance Stress Anxiety

Additional medications:

_____

_____

Radiology Scheduling Exam Questions

Please answer these questions in case we need to order scans:

1. How much do you weigh?_____
2. Do you have asthma?_____
3. Are you allergic to IV contrast, x-ray dye, iodine, or shellfish?_____
4. Are you diabetic?_____
5. Do you have a pacemaker?_____
6. Do you have aneurysm or vascular clips in your body?_____
7. Have you ever been a sheet metal worker?_____
8. Do you have a history of renal failure or are you on dialysis?_____
9. Do you have permanent/tattooed eyeliner?_____
10. Do you have implanted insulin or medication pumps?_____
11. Do you have cochlear ear implants?_____
12. Do you have any bullets or other metal in your body?_____

Date: _____

Physician Signature: _____