Otolaryngology-Head and Neck Surgery • **Return Patient Questionnaire**

Date of Visit: _____

Name: (Last) _____ , (First) _____ , (MI) _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____

Personal Medical History: Have there been any changes to your medical history since your last visit here?
❑ No changes from prior visit ❑ Yes, new medical conditions (please list any changes on the next page)

Surgical History: Have you undergone any additional procedures/surgeries since your last visit here?
❑ No changes from prior visit ❑ Yes, recent surgeries (please list any changes on the next page)

Medications: Have there been any changes to your medications (including prescription medications, supplements, over the counter medications, home remedies, herbs since your last visit here?
❑ No changes from prior visit ❑ Yes, new medications (please list any changes on the next page)

Allergies: Have there been any changes to your medication or food allergies?
❑ No changes from prior visit ❑ Yes, allergies (please list any changes on the next page)

Family History: Have there been any changes to your family history?
❑ No changes from prior visit ❑ Yes, new family history (please list any changes on the next page)

Social History: ❑ No changes from prior visit ❑ Yes my tobacco, alcohol or drug use has changes (please list any changes on the next page)

Review of Systems: Have you experienced any changes in the symptoms below since your last visit?
❑ No changes from prior visit ❑ Yes, new symptoms (please circle below the new symptoms)

Constitutional	Fatigue Fever Night sweats Weight loss Weight gain
Eyes	Changes in vision Double vision Painful eyes Irritation from light
Ears	Pain Hearing loss Ringing Dizziness Imbalance Clogging sensation Drainage
Nose	Runny nose/Post nasal drip Stuffiness/congestion Bloody nose Snoring Sinusitis Altered sense of smell
Throat	Hoarseness Sore throat Difficulty swallowing Voice changes
Allergy	Hives Sneezing Recurrent infections Itchy eyes/nose/ears
Respiratory	Coughing blood Pain with breathing Shortness of breath Wheezing Cough
Cardiac	Chest pain Rapid/irregular heart beat
Gastrointestinal	Abdominal pain Appetite change Heartburn Bowel Problems
Neurological	Clumsiness Convulsions Headache Memory problems Numbness Tingling sensation Weakness
Hematology	Anemia Bleed easily Bruise easily Joint pain Lymph node swelling
Psychiatry	Depression Hallucination Mood changes Sleep disturbances Stress Anxiety

Patient's signature: _____ Date: _____

Reviewed by: _____ Date: _____

Please bring completed form with you to your visit*

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New Personal Medical History: _____

_____

_____

New Surgical History: _____

_____

_____

New Medications: _____

_____

_____

New Allergies: _____

_____

_____

New Family History: _____

_____

_____

New Social History: _____

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Please bring completed form with you to your visit*