

*Health Questionnaire*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Drug allergies and reactions:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Non drug allergies and reactions*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Medications you are currently taking*

|  |  |
| --- | --- |
| Name | Dose |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

*Review of Systems (Please mark yes or no for current symptoms.)*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | yes | no |  |  | yes | no |  |  | yes | no |
| General | Fever |  |  | Throat | Soreness |  |  | Eyes | Pain |  |  |
|  | Chills |  |  |  | Pain |  |  |  | Vision loss |  |  |
|  | Weight loss |  |  |  | Swallowing problem |  |  |  | Excessive tears |  |  |
|  | Fatigue/malaise |  |  |  | Voice problem |  |  |  | Itching/irritation |  |  |
|  | Sleep problems |  |  |  | Bad breath |  |  |  | Drainage |  |  |
|  | Cough |  |  |  | heartburn |  |  | Neck | Lump/mass |  |  |
|  | Headache |  |  |  | Foreign body sensation |  |  |  | Thyroid |  |  |
| Ears | Itching |  |  | Allergy | Urticaria |  |  | Respiratory | Wheezing |  |  |
|  | Pain |  |  |  | Hay fever |  |  |  | Excessive sputum |  |  |
|  | Fullness/pressure |  |  |  | Persistent infections |  |  |  | Hemoptysis |  |  |
|  | Hearing loss |  |  | Neurologic | Headaches |  |  |  | Cough |  |  |
|  | Wax |  |  |  | Syncope/passing out |  |  | Skin | Rash |  |  |
|  | Ringing/buzzing |  |  |  | Seizures |  |  |  | Itching |  |  |
|  | ear drainage |  |  |  | weakness |  |  |  | Ulcers/growths |  |  |
| Nose | Obstruction |  |  | Vestibular | Vertigo (spinning) |  |  |  | Excess scarring |  |  |
|  | Congestion |  |  |  | Dizziness |  |  |  | Bleeding problem |  |  |
|  | Post nasal drip |  |  |  | Joint problems |  |  |  | dryness |  |  |
|  | Facial pain |  |  |  | With head turns |  |  |  |  |  |  |
|  | Bleeding |  |  |  | While sitting |  |  |  |  |  |  |
|  | Runny nose |  |  |  |  |  |  |  |  |  |  |

**

*Family History (Please mark if any blood relative has suffered any of the following.)*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Alcoholism |  | Arthritis |  | Blindness |  | Allergies |  | High cholesterol |  | Kidney disease |  |
| Anemia |  | Asthma |  | Cancer |  | Hearing loss |  | Hypertension |  | Stroke |  |
| Anesthesia problems |  | Bleeding problems |  | Diabetes |  | Heart disease |  | Migraines |  | Thyroid disease |  |

*Past Illness (Please mark if you have had any of these illnesses.)*

|  |  |
| --- | --- |
| Illness | Date of onset |
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*Previous Surgeries (Please list the name, surgeon, and date of any past surgeries.)*

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| --- | --- | --- |
| Name of surgery | Surgeon | Year |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

*Social History (Please mark appropriate responses.)*

Diet: Omnivore Vegetarian Vegan Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of alcohol: Never Occasional/ Social Moderate Daily

Use of tobacco: Never Previously but quit (when):\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes (how many packs per day) \_\_\_\_\_\_\_\_\_\_\_\_

Use of recreational drugs: Never Previously but quit (when):\_\_\_\_\_\_\_\_\_\_\_\_\_ Active (what drugs)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_