

Name (Last, First M.I.) \_\_\_\_\_

Date of Birth (Month/Day/Year) \_\_\_\_\_

# Health History Questionnaire



If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

## 1. Medical History

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> CHF/Heart Failure          | <input type="checkbox"/> Heart Disease                    | <input type="checkbox"/> Palpitations/Racing Heart |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Depression                 | <input type="checkbox"/> HIV/AIDS                         | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Emphysema/COPD             | <input type="checkbox"/> Kidney Disease                   | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> GERD/Heartburn/Acid Reflux | <input type="checkbox"/> Liver Disease                    | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Blood Clots/DVT   |   |   | _____  |
| <input type="checkbox"/> Cancer            |   |   |  |

## 2. Surgical History

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> No surgery               | <input type="checkbox"/> Colonoscopy                           | <input type="checkbox"/> Hernia repair    | <input type="checkbox"/> Spine Surgery    |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Coronary Artery Bypass                | Location _____                            | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Appendectomy             | <input type="checkbox"/> Coronary Artery Stent                 | <input type="checkbox"/> Hip Replacement  | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Breast surgery           | <input type="checkbox"/> Eye Surgery                           | <input type="checkbox"/> Hysterectomy     |   |
|   | <input type="checkbox"/> Gallbladder Surgery (Cholecystectomy) | <input type="checkbox"/> Knee Replacement |   |
|   |  | <input type="checkbox"/> Prostate Surgery |   |

## 3. Social History

- |   |   |   |   |
|---|---|---|---|
| Alcohol Use   | Street Drug Use   | Tobacco Use   | Sexually Active   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never | <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| <input type="checkbox"/> Wine   | <input type="checkbox"/> Marijuana  | Type _____  | <input type="checkbox"/> Not Currently                        |
| <input type="checkbox"/> Beer   | <input type="checkbox"/> Methamphetamines   | <input type="checkbox"/> Current Smoker   | Partners  |
| <input type="checkbox"/> Liquor   | <input type="checkbox"/> Cocaine  | Packs per day _____   | Check all that apply  |
|   | <input type="checkbox"/> Heroin   | <input type="checkbox"/> Former Smoker  | <input type="checkbox"/> Female <input type="checkbox"/> Male |
|   | <input type="checkbox"/> Other  |   | Birth Control / Protection                                    |
|   |   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No      |
|   |   |   | Method _____  |

## 4. Family Medical History Check all that apply.

- I have no family history  
 I have unknown family history

Relationship	Anemia	Anxiety	Arthritis	Asthma	Bleeding Disorder	Blood Clots / DVT	Cancer	CHF/Heart Failure	Depression	Diabetes	Emphysema/COPD	GERD/Heartburn/Acid Reflux	Heart Disease	HIV/AIDS	High Blood Pressure	Kidney Disease	Liver Disease	Palpitations/Racing Heart	Seizures	Stroke	Thyroid Problems	Other	
Father																							
Mother																							
Sibling																							
Maternal Grandmother																							
Maternal Grandfather																							
Paternal Grandmother																							
Paternal Grandfather																							
Other																							

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## 5. Otolaryngology History

Reason for today's visit? \_\_\_\_\_

What treatment have you received for this? \_\_\_\_\_

Check all symptoms that apply.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Fevers          | <input type="checkbox"/> Ear Pain            | <input type="checkbox"/> Runny Nose         | <input type="checkbox"/> Muscle Aches        |
| <input type="checkbox"/> Chills          | <input type="checkbox"/> Ear Drainage        | <input type="checkbox"/> Stuffy Nose        | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> Weight Loss     | <input type="checkbox"/> Nosebleeds          | <input type="checkbox"/> Sinus Pain         | <input type="checkbox"/> Upset Stomach       |
| <input type="checkbox"/> Tired           | <input type="checkbox"/> Congestion          | <input type="checkbox"/> Snoring            | <input type="checkbox"/> Gland Swelling      |
| <input type="checkbox"/> Rash            | <input type="checkbox"/> Sneezing            | <input type="checkbox"/> Dry Mouth          | <input type="checkbox"/> Tremor              |
| <input type="checkbox"/> Itching         | <input type="checkbox"/> Light Sensitivity   | <input type="checkbox"/> Blurry Vision      | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Watery, Itchy Eyes | <input type="checkbox"/> Nervousness/Anxiety |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Hoarse Voice        | <input type="checkbox"/> Double Vision      | <input type="checkbox"/> Daytime Sleepiness  |
| <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Cough               | <input type="checkbox"/> Eye Pain           | <input type="checkbox"/> Numbness            |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain         |  |

Does anyone in your family have hearing loss?  Yes  No

If yes, how are they related?  Parent  Grandparent  Sibling  Children  Aunt  Uncle  Cousin  Other

Is there any other information you would like us to know?