

PATIENT QUESTIONNAIRE

Today's Date _____ Patient Name _____ Date of Birth _____

Primary Care Physician (PCP) _____

Reason for Today's Visit _____

PHARMACY NAME/CROSS STREETS

Medications

Do you take any *prescription* medications or supplements on a regular basis? Yes No

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Social History

Do you use any tobacco or other smoking products? (e.g., cigarettes, marijuana, vaping, chew, etc.) Never
 Not anymore (date quit) _____ Yes

Do you use alcohol? Never Rarely Socially Moderately Heavily

Family History

Hearing loss Anesthesia problems Cancer (if yes, what type?) _____ Heart disease Diabetes

Serious Illnesses/Non-Surgical Hospitalizations

List all current or chronic illnesses (diabetes, heart disease, etc.).

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Allergies

Do you have an allergy to latex? Yes No

Do you have an allergy to any medications? Yes No If so, please list.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Surgical History

List any surgeries you have had.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Have you ever had problems with general anesthesia? Yes No

Have you ever had a blood transfusion? Yes No

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Are you currently experiencing any of the following ENT problems or symptoms?

- | | | |
|--|--|--|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Nasal obstructions | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Pain with swallowing |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Change in taste/smell | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Headache | <input type="checkbox"/> Neck mass |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Head/neck cancer |
| <input type="checkbox"/> Nasal drainage | <input type="checkbox"/> Sore throat | |
| <input type="checkbox"/> Nasal trauma | <input type="checkbox"/> Mouth lesions | |

Do you have any of the following conditions or symptoms?

CONSTITUTIONAL

- Fever
- Chills
- Recent weight gain
- Recent weight loss
- Fatigue
- Other _____

CARDIAC

- Chest Pain
- Palpitations
- Angina
- Congestive heart failure
- Heart attack
- High blood pressure
- Pacemaker
- Heart valve disease
- Rheumatic fever
- Other _____

PULMONARY (LUNGS)

- Wheezing
- Exercise intolerance
- Other _____

DIGESTIVE

- Nausea/vomiting
- Diarrhea
- Constipation
- Hiatal hernia
- Heartburn
- Reflux disease
- Ulcers

- Irritable bowel

- Colitis
- Diverticulitis
- Liver disease
- Other _____

ENDOCRINE

- Diabetes
- Low thyroid
- High thyroid
- Stroke/CVA
- Other _____

SKIN

- Rash
- Eczema
- Other _____

BLOOD/IMMUNE SYSTEM

- Swollen glands
- Blood clots/DVT/PE
- Easy bleeding
- Anemia
- Cancer
- Lupus
- Other _____

MUSCULOSKELETAL

- Arthritis
- Neck/back problems
- Osteoporosis
- Other _____

PSYCHOLOGIC/EMOTION

- Depression
- Anxiety
- Bipolar disorder
- Recent increase in stress
- Other _____

INFECTIOUS DISEASE

- HIV
- Hepatitis A/B/C
- Tuberculosis
- Measles
- Mumps
- Other _____

COGNITIVE CHANGES

- Alzheimer's
- Dementia
- Other _____

OTHER NEUROLOGIC

- Loss of strength
- Numbness/tingling
- Seizures/epilepsy
- Multiple sclerosis