Health History Questionnaire

PERSONAL MEDICAL HISTORY

Please check all that apply

- ☐ Acid Reflux
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Thinners (currently)
- ☐ Bronchitis
- ☐ COPD
- ☐ Cancer
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Food Allergy
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Immune Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disorder
- ☐ Nasal/Sinus Problems
- ☐ Nasal Polyps
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Pregnant (Currently)
- ☐ Rhinitis
- ☐ Sleep Disorder
- ☐ Speech Delay
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsil Infections

FAMILY HISTORY

Please check all that apply

- ☐ Allergies
- ☐ Anemia
- ☐ Angioedema
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bell's Palsy
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Eczema
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disorder
- ☐ Lupus Erythematosus
- ☐ Migraines
- ☐ Meniere's Disease
- ☐ Otosclerosis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tinnitus
- ☐ Vertigo

MEDICATIONS

Please list all medications that you are currently taking including the dose and frequency

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES

Please list all Allergies

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SOCIAL HISTORY

Please check all that apply

- ☐ **Smoking Status** (circle below)
  Former smoker, Never smoked, Current Smoker
- ☐ **Smoking Amount** (circle below)
  1 PPW, 2 PPW, 1/4 PPD, 1/2 PPD, 1 PPD, 2 PPD, 3+PPD
- ☐ **Has smoked since age:** _____
- ☐ **Occupation** _____
- ☐ **Alcohol Intake** (circle below)
  None, Occasional, Moderate, Heavy
- ☐ **Chewing Tobacco** (circle below)
  None, 1/2 Day, 2-4 per day, 5+ per day
- ☐ **Exercise Level** (circle below)
  None, Occasional, Moderate, Heavy
- ☐ **Able to Care for Self**
  Yes or No
- ☐ **Hard at Hearing or Deaf in one or both ears**
  Yes or No
- ☐ **Swimming/Diving**
  Yes or No
- ☐ **Passive Smoke Exposure:**
  Yes or No
- ☐ **Tobacco Years of Use:** _____
- ☐ **Tobacco Cessation Counseling Provided**
  Yes or No
- ☐ **Type of Noise Exposure** (circle all that apply)
  Industrial, Firearms, Explosions/Blasts, Other
- ☐ **Caffeine Intake** (circle below)
  None, Occasional, Moderate, Heavy
- ☐ **Diet** (circle below)
  Regular, Vegetarian, Vegan, Gluten Free, Cardiac Specific, Carbohydrate, Diabetic
- ☐ **Sunscreen Used Routinely**
  Yes or No
- ☐ **Snorkel/SCUBA**
  Yes or No
- ☐ **Frequent Air Travel**
  Yes or No

SURGICAL HISTORY

Please check all that apply

- ☐ Abdominal Surgery
- ☐ Adenoidectomy
- ☐ Adenoidectomy
- ☐ Back Surgery
- ☐ CABG
- ☐ Caesarean Section
- ☐ Cataract Surgery
- ☐ Cervical Spine Surgery
- ☐ Colonoscopy
- ☐ Coronary Artery Stent
- ☐ Ear Surgery
- ☐ Eye Surgery
- ☐ Eyelid Surgery
- ☐ Facelift
- ☐ Gallbladder Surgery
- ☐ GYN Surgery
- ☐ Heart Surgery
- ☐ Joint Replacement
- ☐ Kidney Stone Removal
- ☐ Lumbar Spine Surgery
- ☐ Mastoidectomy
- ☐ Myringotomy Tube Placement
- ☐ Nasal Surgery
- ☐ Neurosurgery
- ☐ Orthopedic Surgery
- ☐ Pacemaker
- ☐ Septoplasty
- ☐ Sinus Surgery
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Urologic Surgery
- ☐ Vascular Surgery
- ☐ Other Surgery's list below
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Review of Systems

Patient: Please check all symptoms that apply to you

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Significant Weight Loss
- ☐ Weight Gain

EYES
- ☐ Double Vision
- ☐ Itching
- ☐ Burning
- ☐ Pain
- ☐ Blurred Vision

EARS
- ☐ Hearing Loss
- ☐ Difficult Hearing
- ☐ Ear Pain
- ☐ Vertigo
- ☐ Tinnitus
- ☐ Ear Pressure
- ☐ Ear drainage/discharge

NOSE
- ☐ Frequent Nose Bleeds
- ☐ Nasal Congestion
- ☐ Rhinorrhea
- ☐ Sinus Pressure
- ☐ Blockage

NEUROLOGIC
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Seizures
- ☐ Numbness
- ☐ Weakness
- ☐ Restless Legs
- ☐ Loss of Consciousness

MOUTH/THROAT
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Mouth Ulcers
- ☐ Teeth Problems
- ☐ Difficulty Swallowing
- ☐ Post Nasal Drip
- ☐ Hoarseness
- ☐ Oral Abnormality
- ☐ Mouth Breathing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Dyspnea on Exertion
- ☐ Palpitations
- ☐ Edema
- ☐ Light headed on Standing

RESPIRATORY
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Hemoptysis
- ☐ Sputum Production
- ☐ Sleep Apnea

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Painful Swallowing
- ☐ Heartburn
- ☐ Increased Appetite
- ☐ Decreased Appetite

HEMATOLOGIC/LYMPHATIC
- ☐ Swollen Glands
- ☐ Abnormal Bruising
- ☐ Bleeding Problems

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Restless Sleep

MUSCULOSKELETAL
- ☐ Muscle Aches
- ☐ Joint Pain/Arthralgias

INTEGUMENTARY
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Growths/Lesions

ENDOCRINE
- ☐ Increased Thirst
- ☐ Increased Drinking
- ☐ Increased Hunger

ALLERGIC/IMMUNOLOGIC
- ☐ Sneezing
- ☐ Runny Nose

OTHER
- ☐ Pregnant

GENITOURINARY
- ☐ Difficulty Urinating
- ☐ Pain During Urination
- ☐ Urinary Retention
- ☐ Incontinence/Loss of Control
- ☐ Hematuria
- ☐ Increased Frequency