Comprehensive
Ear, Nose and Throat, P.C.

Adult Health Questionnaire

Name:	**Age:** **Sex:**
Today's Date:	**Family Doctor:**

List all Drug or Medical Allergies Below:	**Please list any medical problems you have:**

Please list all your current medications:	**Please list all Surgeries you have had:**

Please Answer Below. Y=yes; N=no. If you're not sure, use a question mark.

Do *You*, or Have *You* Had?	**Y**	**N**	**Do *You*, or Have *You* Had?**	**Y**	**N**
Smoke: # packs per day:_____ # years______			Have **Thyroid** problems?		
Use chewing tobacco?			**Heartburn, Reflux,** or **Hiatal Hernia?**		
Use Alcohol (how much)?			Stomach or Duodenal **Ulcer?**		
Have fever, chills, or night sweats?			Blood in your stools?		
Recent weight loss or gain?			Bleeding Problems?		
History of **Stroke**?			Have problems swallowing?		
History of **Seizures**?			**Gall Bladder** problems?		
Have double, blurred vision, blindness?			Had **Hepatitis**, or **Jaundice?**		
Have **Migraine Headaches?**			Had **Pancreatitis?**		
Depression?			Had **Urinary Tract Infections?**		
Other Psychiatric Problems?			Pain, or difficulty with urination?		
Immune System Problems (AIDS)?			Blood in your urine?		
Asthma, or Wheezing?			Kidney problems?		
Chronic **Bronchitis**, or **Emphysema**?			**Arthritis**, or muscle pains?		
Shortness of Breath? (**dyspnea)**			Rashes, Hives, or skin changes?		
Chronic cough?			**Any** history of **cancer?**		
Use extra Oxygen or CPAP?			**Any History of Any anesthesia Problems?**		
History of **Heart Attack?**			**Women only below here:**		
High blood pressure? **(HTN)**			Are you pregnant?		
Heart murmur?			Do you have trouble with periods?		
Have chest pain? **(Angina)**			Have bleeding at unusual times?		
Have ankle swelling?			Get regular breast and pelvic exams?		
Have **Diabetes?**					

What is your occupation?
If retired, what was your occupation?
Are you, or have you been exposed to toxic materials?
Are you, or have you been exposed to very loud noises?

Family History	**Y**	**N**
Is your father living?		
Is he well?		
Is your mother living?		
Is she well?		
Do you have brothers and sisters?		
Are they well?		

If your parents are deceased, please list cause of death and age at death.	
Father: cause	age:
Mother: cause	age:

Any **family history** of:	**Y**	**N**	Any **family history** of:	**Y**	**N**
Hearing loss?`			Diabetes?		
Ear surgeries?			Cancer?		
Tuberculosis?			Asthma?		
High Blood pressure?			Arthritis?		
Heart Disease?			Other inherited diseases?		
Stroke?			Any Pets in the house?		
Bleeding Tendencies?					

Thank You!

Please comment on any other health concerns in the space below.

The information given above is accurate to the best of my knowledge.

Patient signature: ____