8333 North Davis Highway Pensacola, FL 32514 850-474-8320

Name: ______________________________ Date:________________
Email Address for Patient Portal:________________________________

General Questionnaire

Each of the following items is important in helping us find out about and treat the illness that brought you to see us**. Please answer each question completely and accurately as you can**. If you are unsure about a question, please ask one of our medical staff for clarification.

Chief Complaint

1. In a few words, please describe why you are seeing the doctor today:
____

____
____
____
____

2. How long have you had this problem?
____

3. Were you referred by another physician? Y / N If yes, please provide the name and address of the referring physician:
____
____

**If you have a Primary Care Physician, who is NOT the referring physician, please provide us with his/her name and address:
____
____

Past Medical History

4. Have you ever had any of the following (*please circle all that apply*):

High Blood Pressure Heart Attack Abnormal Heart Rhythm Cancer
Heart Failure Heart Murmur Seizures (Type of Cancer: ____________)
Syncope Kidney Disease Liver Disease/Jaundice Anemia
Hepatitis Thyroid Problems Pneumonia Bleeding Problems
Tuberculosis (TB) Arthritis Acid Reflux Substance Abuse
Diabetes Blood Transfusion Stroke DVT / Blood Clot
Depression Radiation Treatment Asthma
Other Conditions you have been treated for:
____
____

PLEASE CONTINUE NEXT PAGE

Ear, Nose, & Throat SM
Adult & Pediatric | Diagnosis | Treatment | Surgery
Medical Center Clinic

Procedures

5. Have you had problems with anesthesia? Y / N

6. Have you ever had any of the following surgeries? *(Place approximate date of surgery in blank)*

Tonsillectomy and/or Adenoidectomy ______________ Thyroidectomy ____________________________
Tympanoplasty ________________________________ Appendectomy ____________________________
Ear Tube Surgery _______________________________ Other ENT Surgery _________________________
Nose or Sinus Surgery ___________________________ Wisdom Teeth Extracted _____________________
Open Heart Surgery _____________________________ Knee Surgery ______________________________
Gallbladder Surgery _____________________________ Neck Surgery ______________________________
Hysterectomy __________________________________
Please list all other surgeries and dates:
____

Family History

7. Do you have Blood Relatives who have any of the following conditions? (Check all that apply):

Mother	**Father**	**Sister**	**Brother**	**Son**	**Daughter**
Heart Disease					
High Blood Pressure					
Problems w/Anesthesia					
Bleeding Problems					
Asthma					
Hearing Loss					
Allergies					
Stroke					
Cancer					

Social History

8. Occupation:
____

9. Marital Status *(Please circle one):* Married Single Divorced Widowed

10. Do you live alone? Y / N If no, who lives with you?
____

11. Do you smoke? Y / N Do you drink alcoholic beverages? Y /N Have you ever smoked? Y / N Average number of drinks/day: _________________ If Yes, when did you quit? ________________________ Have you had a problem with alcoholism? Y /N How many years did you smoke? __________________ How many packs/day on average?
____

12. Have you been HIV tested? Y /N HIV Result: Positive / Negative

13. Are you at risk for AIDS /HIV / Hepatitis? Y /N

14. Women: Is there any chance you could be pregnant? Y / N / Unknown

PLEASE CONTINUE NEXT PAGE

Ear, Nose, & Throat[SM]
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Allergies and Medications

15. Please list any medications that you take on a regular basis (please include non-prescription medications, such as aspirin, herbal treatments, and vitamins)

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

16. Are there any allergies to Medications? Y / N If yes, which ones? ______________________________

Review of Symptoms

17. Please circle all symptoms which you have now:

General:	Fatigue	Chills	Fever	Night Sweats	Weight Loss/Gain	
Eyes:	Change in Vision	Double Vision	Wear Glasses	Dry Eyes	Tearing	
Ears:	Hearing Loss	Ear Pain	Ear Drainage	Ringing	Dizziness	
Nose:	Nasal Congestion	Nasal Bleeding	Nasal Drainage	Sinus Pain		
Throat:	Difficulty Swallowing	Change in Voice	Feeling of Lump in Throat	Throat Pain		
Lungs:	Shortness of Breath	Frequent Cough	Wheezing	Coughing Blood		
Cardiovascular:	Chest Pain	Irregular Heartbeat	Ankle Swelling			
Gastrointestinal:	Heart Burn	Nausea/ Vomiting	Diarrhea	Constipation	Vomiting Blood	Abdominal Pain
Neurological:	Depression	Memory Loss	Weakness	Numbness	Tingling	
Musculoskeletal:	Back Pain	Joint Pain	Arm/Leg Pain	Muscle Weakness		
Skin:	Skin Cancer	Skin Disease	Rash			
Endocrine:	Increased Appetite	Excessive Thirst	Heat/Cold Tolerance			
Allergy:	Itchy/Watery Eyes	Facial Swelling	Hives			

PLEASE CONTINUE NEXT PAGE

Health Maintenance

18. If the patient is a child:

Are his/her immunizations up to date? Y / N Is the child in daycare? Y / N
Date of last influenza shot:____________ Date of last mammogram:__________________
Date of last Prevnar shot:_____________ Date of last Pneumovax shot:________________
Date of last colonoscopy:______________
19. Age: ____________ Height: ____________ Weight: ____________ Blood Pressure: ____________

The information answered above it true and accurate to the best of my knowledge.

____ __________________________________
Patient's Signature Date

____ __________________________________
Physician's Signature Date