Ear, Nose, & Throat SM
Adult & Pediatric | Diagnosis | Treatment | Surgery
Medical Center Clinic
8333 North Davis Highway Pensacola, FL 32514 850.474.8320

General Questionnaire

Patient Name: _____ **Date:** _____

Each of the following items is important in helping us understand 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 assistance.

Chief Complaint

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

2. How long have you had these issues/complaints? _____
_____

3. Were you referred to us by another Physician? ___ Yes ___ No

If Yes, which 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: *(Check all that apply)*

__ High blood pressure
__ Heart failure
__ Syncope
__ Hepatitis
__ Tuberculosis (TB)
__ Diabetes
__ Asthma
__ Heart attack
__ Heart murmur
__ Thyroid problems
__ Kidney disease
__ Arthritis
__ Blood transfusion
__ Radiation treatment
__ Abnormal heart
__ Rhythm seizures
__ Liver disease/ Jaundice
__ Pneumonia
__ Acid reflux
__ Stroke
__ Depression
__ Cancer
(Type: _____)
__ Anemia
__ Latex allergy
__ Bleeding problems
__ Substance abuse
__ DVT/blood clot

Other conditions you have been treated for: _____
_____
_____
_____

Have you had problems with anesthesia? ___ Yes ___ No

If Yes, what problems with anesthesia did you have? _____
_____

5. Have you ever had any of the following surgeries: (*Check all that apply and date of surgery*)

__ Thyroidectomy : _____
__ Appendectomy : _____
__ Other ENT Sugery : _____
__ Wisdom Teeth Extracted : _____
__ Knee surgery : _____
__ Neck surgery : _____
__ Hand Surgery : _____
__ Back Surgery : _____
__ Tonsillectomy and/or Adenoidectomy : _____
__ Tympanoplasty (Ear Tubes) : _____
__ Nose or Sinus Surgery: _____
__ Open Heart Surgery: _____
__ Gallbladder Surgery : _____
__ Hysterectomy : _____

Please list any other surgeries you have had that were not listed above, include dates of surgery.

_____
_____
_____

6. Allergies to medications? __ Yes __ No
If Yes, please list all medication allergies:

_____
_____
_____

7. Medications that you take on a regular basis: *(Pease include non-prescription medications such as: aspirin, herbal treatments, and vitamins).* No medications: **Go to next section**

_____
_____
_____

For additional medications, please write on the back of this page or provide a complete list to your provider.

8. If the patient is a child, are immunizations/vaccines up to date? __ Yes __ No Is the child in daycare? __Yes __ No

Social History:

9. Occupation: _____

10. Do you live alone: __ Yes __ No
If No, who lives with you? _____

11. Marital Status: ___ Married ___ Divorced ___ Single ___Widowed

12. Do you smoke? __ Yes __ No Have you ever smoked? __ Yes __ When did you quit? _____
How many years did you smoke? _____ How many packs/day (average)? _____

13. Do you drink alcohol? __ Yes __ No
If yes, average number of drinks/day: _____ Have you had a problem with alcholism? __ Yes __ No

14. Have you been tested for HIV? __ Yes __ No
HIV test Results: __ Positive __ Negative

15. Are you at risk for AIDS, HIV, Hepatitis, STDs, Drug Abuse, Previous Blood Transfusions?
__ Yes __ No If Yes, Please explain: _____

16. Women: Is there any chance you could be pregnant? __ Yes __ No __Unknown

CONTINUE TO NEXT PAGE

Family History

17. Do you have ***immediate relatives*** who have any of the following conditions? *(Please specify which relative: Mother, Father, Daughter, Son, Sister, Brother).*

Heart Disease: _____
High Blood Pressure: _____
Problems with anesthesia bleeding problems asthma: _____
Hearing loss: _____
Allergies: _____
Stroke: _____
Cancer & type: _____

Review of systems

Please mark all symptoms you are currently experiencing:

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Lungs: ψψ ² KŜŜÎλ∃ ψψ /2dz∃Kλ∃ ōf22Ř ψψ /KŜăΰ LJI·λ

Cardiovascular: ψψ LλλŜ∃dzfI·λ KŜI·λΰ ōŜI·ΰ ψψ I ŜI·λΰ ōdzλ

Gastrointestinal: ψψ bI·dzăŜI· ψψ Vomiting ψψ .f22Ř λ∃Ø2Yλΰ ψψ5λI·λλKŜI· ψψ /2yãΰλLJI·ΰλŽ ψψ !ōŘ2YλI·f LJI·λ

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17. Age:_____ Height:_____ Weight:_____ Approximate blood pressure:_____

All of the information provided on this form is true and accurate.

_____ _____
Patients Signature Date

_____ _____
Physician's Signature Date