Mile High Otolaryngology, LLC Patient Questionnaire

Welcome to our office. Please provide answers to the following questions so we may better care for you.

Patient Name **(please print)** ______________________ **DOB**________ **Date**_________

Primary Care Physician (PCP) ____

Reason for today's visit ____

*****PHARMACY NAME/CROSS STREETS*****

____

Medications

Do you take any ***prescription*** medications, supplements or vitamins on a regular basis?

No_____ Yes_____

1______________________________ 2_________________________________

3______________________________ 4_________________________________

5______________________________ 6_________________________________

7______________________________ 8_________________________________

Social History

****Do you use tobacco?** Never_____ Former ___

Smoker (date quit) ________ less than 1pack per day____

1 pack per day____ 1-2 packs per day____

3 packs per day____ oral tobacco____

*****Do you use alcohol?**

Never ___Rare ___Socially ___Moderate ___Heavy___

Family History *(circle what applies)*

1. Hearing loss
2. Heart disease
3. Anesthesia problems
4. Diabetes
5. Cancer (if yes what type?) _____________________

Serious Illnesses/Non-Surgical Hospitalizations

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

1______________________________ 2________________________________

3______________________________ 4________________________________

5______________________________ 6________________________________

7______________________________ 8________________________________

Allergies

Do you have an allergy to latex? No______ Yes________

Do you have an allergy to any medications, suppliments or vitamins? No___ Yes_____ if so, please list.

1______________________________ 2_________________________________

3______________________________ 4_________________________________

5______________________________ 6_________________________________

Surgical History

List any surgeries you have had.

1______________________________ 2_________________________________

3______________________________ 4_________________________________

5______________________________ 6_________________________________

Have you ever had problems with general anesthesia? No______ Yes_______

Have you ever had a blood transfusion? No________ Yes_________

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Patient Name **(please print)** ______________________ **DOB** ________ **Date** ___________

Does the patient *currently* have any of the following ENT problems or symptoms?

- Ear infections ☐
- Ear pain ☐
- Hearing problems ☐
- Ringing in the ears ☐
- Dizziness ☐
- Snoring ☐
- Sleep apnea ☐
- Nasal drainage ☐
- Nasal trauma ☐
- Sinus infections ☐
- Nasal obstruction ☐
- Nosebleeds ☐
- Facial pain ☐
- Change in taste/smell ☐
- Headache ☐
- Tonsillitis ☐
- Sore throat ☐
- Mouth lesions ☐
- Hoarseness ☐
- Difficulty swallowing ☐
- Pain with swallowing ☐
- Cough ☐
- Shortness of breath ☐
- Neck Mass ☐
- Head/neck cancer ☐

Does the patient have any of the following conditions or symptoms (check for yes):

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 ☐
- Other ______________________

Neurologic
- Loss of strength ☐
- Numbness/tingling ☐
- Seizures/epilepsy ☐
- Multiple sclerosis ☐
- Stroke/CVA ☐
- Migraine ☐
- 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/Emotional
- 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 ______________________