

Mile High Otolaryngology, LLC Patient Questionnaire

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

Name _____ DOB _____ Today's Date _____

Primary Care Physician (PCP) _____

Who referred you to us? (PCP, friend, staff, insurance, etc.) _____

Reason for today's visit _____

Medications

Do you take any prescription medications or supplements 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 1 pack 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 3. Anesthesia problems 5. Cancer (if yes what type?)

2. Heart disease 4. Diabetes _____

Serious Illnesses/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? 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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Review of Systems

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

Ear, Nose or Throat

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

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

Constitutional

Fever	<input type="checkbox"/>
Chills	<input type="checkbox"/>
Recent weight gain	<input type="checkbox"/>
Recent weight loss	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>

Cardiac

Chest Pain	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>
Heart Valve Disease	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Pulmonary (Lungs)

Wheezing	<input type="checkbox"/>
Exercise intolerance	<input type="checkbox"/>

Digestive

Nausea/vomiting	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>
Reflux disease	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>
Irritable bowel	<input type="checkbox"/>
Colitis	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Endocrine

Diabetes	<input type="checkbox"/>
Low thyroid	<input type="checkbox"/>
High thyroid	<input type="checkbox"/>

Neurologic

Loss of strength	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Skin

Rash	<input type="checkbox"/>
Eczema	<input type="checkbox"/>

Blood/Immune System

Swollen glands	<input type="checkbox"/>
Blood clots/DVT/PE	<input type="checkbox"/>
Easy bleeding	<input type="checkbox"/>
Anemia	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Lupus	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Musculoskeletal

Arthritis	<input type="checkbox"/>
Neck/back problems	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>

Psychologic/Emotional

Depression	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>
Recent increase in stress	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Infectious Disease

HIV	<input type="checkbox"/>
Hepatitis A/B/C	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>
Measles	<input type="checkbox"/>
Mumps	<input type="checkbox"/>