**New Patient** **Questionnaire**

**Otorhinolaryngology- Head & Neck Surgery**

2019-04-24 FINAL 1 of 3

|  |  |  |  |
| --- | --- | --- | --- |
| Name | MRN | DOB | Date |
| Telephone |  |  |  |  |
| H | W | M |  |  |
| Pharmacy |  |  |  |  |
| Name | Telephone |  |  |
| How did you hear about us?* Sent by another physician (If so, please give name below.)
* Sent by a friend
* Internet search
* UT reputation
* Other *(Specify)*
 |
| Physician #1 ( sent by this physician) |
| Name | Fax |  | Telephone |  |
| Address | City, State |  | Zip |  |
| Physician #2 ( sent by this physician) |
| Name | Fax |  | Telephone |  |
| Address | City, State |  | Zip |  |

# Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

# START HERE:

**What symptom gives you the most trouble?**

**Review of Systems**

*The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Treated by another****physician** |  |  | **Yes** | **No** | **Treated by****another physician** |
| **General** |  |  |  | **Gastro-intestinal** |
| Nausea |  |  |  | Heartburn |  |  |  |
| Weight gain |  |  |  | Belly pain |  |  |  |
| Weight loss |  |  |  | Diarrhea |  |  |  |
| Fevers/chills |  |  |  | Constipation |  |  |  |
| **Ears, Nose & Throat** | Vomiting |  |  |  |
| Hoarseness |  |  |  | **Skin** |
| Hearing loss |  |  |  | Rashes |  |  |  |
| Draining ear |  |  |  | Ulcers |  |  |  |
| Vertigo |  |  |  | **Musculo-skeletal** |
| Loud snoring |  |  |  | Muscle pain |  |  |  |
| Daytime sleepiness |  |  |  | Muscle weakness |  |  |  |
| Mouth sores |  |  |  | **Endocrine** |
| Tooth problems |  |  |  | Cold intolerance |  |  |  |
| Painful/difficult swallowing |  |  |  | Heat intolerance |  |  |  |
| Ringing in the ears |  |  |  | Excessive thirst |  |  |  |
| **Eyes** | **Hematologic** |
| Double vision |  |  |  | Anemia |  |  |  |
| Blurry vision |  |  |  | Bleeding |  |  |  |
| **Cardiac** | Bruising |  |  |  |
| Chest pain |  |  |  | **Neurological** |
| Short of breath |  |  |  | Seizures |  |  |  |
| **Respiratory** | **Psychiatric** |
| Wheezing |  |  |  | Depression |  |  |  |
| Cough |  |  |  | Anxiety |  |  |  |

# Past History

Do you have any of the following medical problems?

 Arthritis

 Asthma

 Bleeding disorder

 Cataracts

 Chronic fatigue syndrome

 Depression

 Diabetes

 Fibromyalgia

 Gastritis

 Glaucoma

 Hepatitis

 High blood pressure

 Heart disease

 Immunodeficiency

 Kidney disease

 Meningitis

 Migraine headache

 Mitral valve prolapse

 Peptic ulcer disease

 Seizures

 Thyroid disease

 Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

 Yes

 No

*(If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

 Yes

 No

*(If yes, please give details.)*

# Family History

Do any of your family members have any of the following conditions?

|  |  |
| --- | --- |
|  Allergy Asthma Bleeding disorder Cancer |  Cystic fibrosis Heart disease Immunodeficiency |

# Social History

|  |  |
| --- | --- |
| What is your occupation? |  |
| Have you had any recent change in your home or work environment? Yes No | Details |
| Do you smoke? Yes No | Details |
| Do you drink alcoholic beverages? Yes No | Details |
| Have you ever used cocaine or other illicit substances? Yes No*.* | Details |