Ear, Nose and Throat Past Surgical History:

1. _____ 3. _____

2. _____ 4. _____

Other Past Surgeries / Illnesses / Injuries / Hospitalizations:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Diagnostic Studies (CT, LAB, etc.):

1. _____ 3. _____

2. _____ 4. _____

Please check Yes or No if you currently have any of the following problems:

1. CONSTITUTIONAL	YES	NO
Good General Health		
Recent Weight Change		
Night Sweats, Fevers		
Fatigue		

2. INTEGUMENTARY (SKIN/BREAST)	YES	NO
Change in Hair or Nails		
Rashes or Itching		

3. EARS/NOSE/MOUTH/THROAT/EYES	YES	NO
Hearing Loss/ Ringing / Dizziness		
Sinus Problems		
Nose Bleeds		
Sore Throat / Voice Change		
Wear Glasses / Contacts		
Eye Disease or Injury		

4. NECK	YES	NO
Neck Mass		
Neck Pain		
Neck Stiffness		
Neck Swelling		
Swollen Glands		

5. RESPIRATORY	YES	NO
Shortness of Breath		
Cough		
Wheezing		
Coughing up Blood		

6. GASTROINTESTINAL	YES	NO
Nausea / Vomiting		
Abdominal Pain		
Bowel Problems		
Chest Burning / Pressure		

7. GENITOURINARY	YES	NO
Blood in Urine		
Kidney Stones		

8. MUSCULOSKELETAL	YES	NO
Muscle Pain or Cramps		
Stiffness / Swelling Joints		
Joint Pain		

9. NEUROLOGICAL	YES	NO
Frequent Headaches		
Paralysis or Tremors		
Convulsions / Seizures		
Numbness / Tingling		

10. PSYCHIATRIC	YES	NO
Confusion / Memory Loss		
Depression		

11. ENDOCRINE	YES	NO
Excessive Thirst / Urination		
Thyroid Disease		
Hormone Problem		

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

PHYSICIAN STATEMENT: I have reviewed the questionnaire with the patient.

Signed: _____ Date: _____