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. ______________________

2. ______________________

Vaccines:

Date of last flu vaccine: ______________________

Date of last pneumonia vaccine: ______________________

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

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

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

5. GASTROINTESTINAL	YES	NO
Nausea / Vomiting		
Chest Burning / Pressure		

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

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

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

9. PSYCHIATRIC	YES	NO
Confusion / Memory Loss		
Depression		
Anxiety		

10. 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:**______________________