CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

Medical History Questionnaire (ENT)

Patient Name: _____ **Today's Date**: _____
Last First MI

Birth date: _____ **Age**: _____ **Gender**: ☐ Male ☐ Female **Accompanied by**: _____

Primary Care Physician: _____ **Referring Doctor**: _____

Reason for Visit: _____

Pharmacy Name: _____ **Pharmacy Location**: _____

Drug Allergies: ☐ Yes ☐ No If yes, list drug allergies and how you reacted: _____

List of current medications: _____

Surgical History

Have you had any of the following procedures? Please check all that apply.

☐ Adenoidectomy	☐ Cosmetic Surgery	☐ Ear Surgery	☐ Neck Surgery	☐ Nose Surgery
☐ Sinus Surgery	☐ Thyroid Surgery	☐ Vocal Cord Surgery	☐ Appendectomy	☐ Brain Surgery
☐ Eye Surgery	☐ Gallbladder Surgery	☐ Heart Surgery	☐ Joint Replacement	☐ Organ Transplant
☐ Pacemaker	☐ Skin Biopsy	☐ Spine Surgery	☐ Tonsillectomy	

Comment(s): _____

Medical History

Have you had or do you currently have any of the following conditions? Please check all that apply.

☐ Acid Reflux	☐ ADD/ADHD	☐ Anemia	☐ Anesthesia Complications	☐ Arthritis
☐ Asthma	☐ Atrial Fibrillation	☐ Autoimmune Disease	☐ Bleeding Problem	☐ Diabetes
☐ Cancer	☐ COPD	☐ Dementia	☐ Developmental Delay	☐ Heart Disease
☐ Dizziness	☐ Ear Problems	☐ Headache	☐ Hearing Loss	☐ Liver Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/AIDS	☐ Kidney Disease	☐ Seizures
☐ Nasal Fracture	☐ Nerve/Muscle Disease	☐ Nosebleeds	☐ Seasonal Allergies	☐ Stroke
☐ Sickle Cell Disease	☐ Sinus Disease	☐ Sleep Apnea	☐ Sleeping Problem	☐ Voice Disorder
☐ Thyroid Disease	☐ TMJ Problem	☐ Tuberculosis	☐ Speech Impairment	

Comment(s): _____

Family History

Please check any of the following diseases/conditions that any of your blood relatives have been diagnosed with.

☐ Asthma	☐ Cancer	☐ Clotting Disorder	☐ Diabetes	☐ Hearing Loss	☐ Heart Disease
☐ High Blood Pressure	☐ Migraines	☐ Arthritis	☐ Rashes/Skin Problems	☐ Seizures	☐ Sleep Apnea
☐ Stroke	☐ Thyroid Cancer	☐ Thyroid Disease	☐ Unknown		

Comment(s): _____

Social History

Tobacco Use

☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Never	☐ Former Smoker
☐ Passive	☐ Heavy Smoker	☐ Light Smoker	

Smokeless Tobacco Use

☐ Current User ☐ Never Used ☐ Former User

Comments on your history with tobacco: _____

Alcohol Use: ☐ Yes ☐ No *Drug Use*: ☐ Yes ☐ No

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Medical History Questionnaire (ENT)

Review of Systems

Please check all systems which the patient has currently, or has had recently. If Yes, please explain in these symptoms in the comment section. If you have not experienced a medical problem under the symptom listed, please check the No box.

Constitutional Symptoms (ex: fatigue, fever, difficulty sleeping) ☐ Yes ☐ No
Comment: _____

Gastrointestinal Symptoms (ex: nausea, heartburn, difficulty swallowing) ☐ Yes ☐ No
Comment: _____

Neurological Symptoms (ex: speech difficulties, migraines, dizziness, headaches, seizures) ☐ Yes ☐ No
Comment: _____

Integument (Skin) Symptoms (ex: new skin lesions, lumps, change in mole appearance) ☐ Yes ☐ No
Comment: _____

Genitourinary Symptoms (ex: urgency, pain or burning with urination, kidney stones) ☐ Yes ☐ No
Comment: _____

Musculoskeletal Symptoms (ex: muscular weakness, twitching, joint pain) ☐ Yes ☐ No
Comment: _____

Head, Ear, Nose, or Throat Symptoms (ex: hearing loss, snoring) ☐ Yes ☐ No
Comment: _____

Endocrine Symptoms (ex: weight gain, weight loss, history of thyroid problems) ☐ Yes ☐ No
Comment: _____

Cardiovascular Symptoms (ex: chest pain, irregular heartbeats) ☐ Yes ☐ No
Comment: _____

Eye Symptoms (ex: eye discomfort, changes in vision) ☐ Yes ☐ No
Comment: _____

Respiratory Symptoms (ex: shortness of breath, hoarseness, cough) ☐ Yes ☐ No
Comment: _____

Psychiatric Symptoms (ex: anxiety, depression) ☐ Yes ☐ No
Comment: _____

Allergic-Immunologic Symptoms (ex: environmental allergies, immune deficiency) ☐ Yes ☐ No
Comment: _____

Heme (Blood)-Lymph Symptoms (ex: swollen lymph nodes, easy bleeding or bruising) ☐ Yes ☐ No
Comment: _____

Activities of Daily Living

Are you deaf or do you have serious difficulty hearing?
☐ Yes ☐ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses?
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
☐ Yes ☐ No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)
☐ Yes ☐ No

Do you have difficulty dressing or bathing? (5 years old or older)
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (5 years old or older)
☐ Yes ☐ No

Travel Screening

Have you traveled outside the U.S. within the last 3 months?
☐ Yes ☐ No If so, where? _____

Form Completed By: _____ **Effective Date:** _____ ***Entered Into Epic?*** _____