Charlotte Eye Ear Nose & Throat Associates, P.A.

Medical History Questionnaire

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

Birthdate: _____ **Age:** _____ Yr./Mo **Gender:** ☐ Male ☐ Female ☐ Twin ☐ Adopted **Accompanied by:** _____

Primary Care Physician: _____ **Doctor who referred the patient:** _____

Other Physicians (specify): _____

Reason for Visit: _____

Medical Conditions:

Has the patient ever been diagnosed with any of the following?

Amblyopia (lazy eye)	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Psychiatric Illness	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Hepatitis (A, B, or C)	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Strabismus	☐ Yes ☐ No
Type: _____ When? _____		High Cholesterol or Lipids	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HIV	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Environmental Allergies	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Gastroesophageal Reflux	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		

List any other medical illness: _____

_____

List any past surgeries or hospitalizations (please include year)**:** _____

_____

Fill out only if patient is a child under 5 years of age

Current Weight: _____ Birth Weight: ____ lbs. ____ ozs. or ____ gms. Number of Siblings: _____

Premature at birth ☐Yes ☐No If yes, born at ____weeks, why? _____ Brothers: ____ Ages:_____

Grade in School: _____ School Attending: _____ Sisters: ____ Ages:_____

ADHD/ADD	☐Yes ☐No	Failure to Thrive	☐Yes ☐No	Oxygen after birth	☐Yes ☐No
Daycare	☐Yes ☐No	Growth Delays	☐Yes ☐No	Speech Delay	☐Yes ☐No
Class Size: _____		Household Smoker	☐Yes ☐No	Drug use during pregnancy	☐Yes ☐No
Development Delay	☐Yes ☐No	Low % on growth chart	☐Yes ☐No	Alcohol use during pregnancy	☐Yes ☐No

Drug Allergies:

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

_____

List current medications (i.e. over the counter medications, herbs, vitamins, aspirin, coumadin, etc)**:** ☐ See Attached List ☐ List continued on back

_____

Family Health History:

Amblyopia (lazy eye)	☐ Yes ☐ No	Ear Infections	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Environmental Allergies	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Strabismus	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Stroke/Seizure	☐ Yes ☐ No

Family History Unknown ☐ Other Family Health History: _____

Social History:

Alcohol Usage	☐ Yes	☐ No	☐ Quit _____	Exposure to second hand smoke	☐ Yes ☐ No
Cigarette Smoking	☐ Yes	☐ No	☐ Quit _____	Live alone	☐ Yes ☐ No
Chewing Tobacco	☐ Yes	☐ No	☐ Quit _____	Occupation: _____	

Review of Systems:

Please check all symptoms which the patient has currently, or has had recently. Check YES, please explain on the back..

General (ex: unintentional weight change)	☐ Yes ☐ No	Gastrointestinal (ex: reflux)	☐ Yes ☐ No	Blood (ex: bruising)	☐ Yes ☐ No
Ear, Nose, or Throat (ex: hearing loss, snoring)	☐ Yes ☐ No	Kidney (ex: stones)	☐ Yes ☐ No	Endocrine (ex: thyroid)	☐ Yes ☐ No
Eye (ex: blurry vision)	☐ Yes ☐ No	Bone, Joint, or Muscle (ex: arthritis, joint swelling)	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Heart (ex: chest pain, murmurs)	☐ Yes ☐ No	Skin (ex: masses, lesions)	☐ Yes ☐ No	Psychiatric (ex: anxiety, depression ADD, ADHD)	☐ Yes ☐ No
Lung (ex: wheezing)	☐ Yes ☐ No	Neurological System (ex: seizures, convulsions headaches)	☐ Yes ☐ No		