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		

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	☐ Cancer
☐ Cancer	☐ COPD	☐ Dementia	☐ Developmental Delay	☐ Diabetes
☐ Dizziness	☐ Ear Problems	☐ Headache	☐ Hearing Loss	☐ Heart Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/AIDS	☐ Kidney Disease	☐ Liver Disease
☐ Nasal Fracture	☐ Nerve/Muscle Disease	☐ Nosebleeds	☐ Seasonal Allergies	☐ Seizures
☐ Sickle Cell Disease	☐ Sinus Disease	☐ Sleep Apnea	☐ Sleeping Problem	☐ Stroke
☐ Thyroid Disease	☐ TMJ Problem	☐ Tuberculosis	☐ Speech Impairment	☐ Voice Disorder

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

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

Medical History Questionnaire (ENT)

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?*** _____