Name (Last, First M.I.) _____

Date of Birth (Month/Day/Year) _____

Health History Questionnaire

UR MEDICINE

If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

1. Medical History

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ CHF/Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ GERD/Heartburn/ Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Palpitations/Racing Heart
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other _____ _____

2. Surgical History

- ☐ No surgery
- ☐ Anesthesia Complications
- ☐ Appendectomy
- ☐ Breast surgery
- ☐ Colonoscopy
- ☐ Coronary Artery Bypass
- ☐ Coronary Artery Stent
- ☐ Eye Surgery
- ☐ Gallbladder Surgery (Cholecystectomy)
- ☐ Hernia repair Location _____
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Replacement
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Organ Transplant
- ☐ Other _____ _____

3. Social History

Alcohol Use
☐ Yes ☐ No ☐ Never
☐ Wine
☐ Beer
☐ Liquor

Street Drug Use
☐ Yes ☐ No ☐ Never
☐ Marijuana
☐ Methamphetamines
☐ Cocaine
☐ Heroine
☐ Other

Tobacco Use
☐ Yes ☐ No ☐ Never
Type _____
☐ Current Smoker
Packs per day _____
☐ Former Smoker

Sexually Active
☐ Yes ☐ No
☐ Not Currently
Partners
Check all that apply
☐ Female ☐ Male
Birth Control / Protection
☐ Yes ☐ No
Method _____

4. Family Medical History Check all that apply.

☐ I have no family history
☐ I have unknown family history

Relationship	*Anemia*	*Anxiety*	*Arthritis*	*Asthma*	*Bleeding Disorder*	*Blood Clots /DVT*	*Cancer*	*CHF/Heart Failure*	*Depression*	*Diabetes*	*Emphysema/COPD*	*GERD/Heartburn/Acid Reflux*	*Heart Disease*	*HIV/AIDS*	*High Blood Pressure*	*Kidney Disease*	*Liver Disease*	*Palpitations/Racing Heart*	*Seizures*	*Stroke*	*Thyroid Problems*	*Other*
Father																						
Mother																						
Sibling																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Other																						

Name (Last, First M.I.) _____

Date of Birth (Month/Day/Year) _____

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Otolaryngology History

Reason for today's visit? _____

What treatment have you received for this? _____

Check all sympoms that apply.

- ☐ Fevers
- ☐ Chills
- ☐ Weight Loss
- ☐ Tired
- ☐ Rash
- ☐ Itching
- ☐ Headaches
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Sneezing
- ☐ Light Sensitivity
- ☐ Sore Throat
- ☐ Hoarse Voice
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Runny Nose
- ☐ Stuffy Nose
- ☐ Sinus Pain
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Blurry Vision
- ☐ Watery, Itchy Eyes
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Chest Pain
- ☐ Muscle Aches
- ☐ Heartburn
- ☐ Upset Stomach
- ☐ Gland Swelling
- ☐ Tremor
- ☐ Depression
- ☐ Nervousness/Anxiety
- ☐ Daytime Sleepiness
- ☐ Numbness

Does anyone in your family have hearing loss? ☐ Yes ☐ No

If yes, how are they related? ☐ Parent ☐ Grandparent ☐ Sibling ☐ Children ☐ Aunt ☐ Uncle ☐ Cousin ☐ Other

Is there any other information you would like us to know?