New Patient Questionnaire

Date _____ ☐ ***Male*** ☐ ***Female***

Name _____ ***Marital Status*** _____

Address _____ ***Occupation*** _____

_____ ***Age*** _____ ***Date of Birth*** _____
City *State* *Zip*

Home phone _____ ***Work phone*** _____

Symptoms: *Please mark (x) in the available blanks if any of the following apply to you* ***Now*** *or in the* ***Past.***

Yes	No	***Head, Eyes, Ears, Nose, Throat***
☐	☐	Noise Exposure
☐	☐	Head Injury or Concussion
☐	☐	Draining or Painful Ears
☐	☐	Hearing Loss
☐	☐	Ringing in Ears
☐	☐	Dizziness or Loss of Balance
☐	☐	Chronic Facial Pain or Headaches
☐	☐	Chronic Nasal Congestion or Drainage
☐	☐	Frequent Nose Bleeds
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
☐	☐	Throat Pain
☐	☐	Jaw Pain
☐	☐	Chronic Cough
☐	☐	Tooth pain/loose teeth/bite problems
☐	☐	Snoring/Sleep Apnea
☐	☐	Double vision/eye pain/change in vision
		General
☐	☐	Unexplained fever/night sweats
☐	☐	Unexplained weight loss or gain
☐	☐	Joint pains and swelling
		Lungs
☐	☐	Coughing up blood
☐	☐	Persistent wheezing/asthma
☐	☐	Shortness of breath
☐	☐	Abnormal chest x-ray
		Heart - Circulation
☐	☐	Chest pain
☐	☐	Heart palpitation
☐	☐	Leg vein trouble/Leg pain when walking
☐	☐	Ankle swelling

Past Surgeries: *List type of operation and date:*

_____

_____

_____

_____

_____

_____

_____

Yes	No	***Stomach - Intestinal***
☐	☐	Heartburn or regurgitation
☐	☐	Indigestion
☐	☐	Frequent or severe stomach pain
☐	☐	Frequent or severe vomiting
☐	☐	Vomiting blood
		Urinary
☐	☐	Frequent urination/Trouble holding urine
☐	☐	Trouble starting urine
☐	☐	Urinate more than two times a night
		Nervous System
☐	☐	Fainting spells (blackouts)
☐	☐	Convulsions (seizures, fits, epilepsy)
☐	☐	Tremor (shaking, trembling)
☐	☐	Paralysis (or weakness or any body part)
☐	☐	Numbness (body parts "go to sleep")
		Females
☐	☐	Pregnant
		Date of last period _____ / _____ / _____

Past Medical History: *List type of illness, place and date:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

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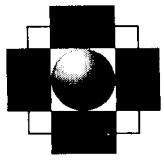

CAROLINA
EAR NOSE & THROAT
ASSOCIATES
OTOLARYNGOLOGY-HEAD & NECK SURGERY
FACIAL PLASTIC SURGERY

Medications: *What prescribed medicines are you taking (list dose and frequency)? Include non-precription medicines, herbal, supplements and/or vitamins. Attach separate sheet if space below is not sufficient.*

Health History: *Have you had any of the following?*

Yes	*No*	
☐	☐	Cancer (type)
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Liver disease, yellow jaundice, hepatitis
☐	☐	Mental troubles or nervous breakdown
☐	☐	Pneumonia
☐	☐	Artificial joints or heart valves
☐	☐	Do you take antibiotics when you go to the dentist?
☐	☐	Serious injury/accident
☐	☐	Diabetes
☐	☐	Tuberculosis (TB)
☐	☐	Uncontrolled bleeding
☐	☐	Kidney disease
☐	☐	HIV/AIDS
☐	☐	Difficulty with anesthetic
☐	☐	Heart attack
☐	☐	Thyroid disease
☐	☐	Abnormal EKG
☐	☐	Stroke
☐	☐	Facial fracture or jaw fracture
☐	☐	Have you used aspirin within the last 2 weeks? How much? _____

Drug Allergies: Reactions

Do you have any allergies to latex? ☐ **Yes** ☐ **No**

Social History:

Smoking: ☐ cigarettes ☐ pipe ☐ cigars ☐ none ☐ quit

Number of years: _____ Daily amount: _____

Alcohol: ☐ beer ☐ wine ☐ other liquors ☐ none ☐ quit

Amount per week: _____

Do you use marijuana? ☐ Yes ☐ No

Do you use other recreational drugs? ☐ Yes ☐ No

Family Health History:

Family Member	Age	If Living Present Health			If Not Living	
		Good	Fair	Poor	Age at Death	Cause of Death
Mother						
Father						
Brothers/ Sisters						
Children						

Phys. Signature: _____ Date: _____

Phys. Review Date: _____ Initials: _____

Phys. Review Date: _____ Initials: _____

Phys. Review Date: _____ Initials: _____

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