PHYSICIANS' CLINIC
of Iowa, P.C.

EAR, NOSE & THROAT QUESTIONNAIRE

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No

Height (feet/inches) _____ Weight (pounds) _____ Date of last influenza vaccine _____

Family Physician _____ Referring Physician _____

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____

Main reason for your visit: _____

_____

_____

REVIEW OF SYSTEMS: *Please check all symptoms you have experienced in the last MONTH. When rating your pain, use 0 as no pain and 10 as maximum pain.*

Ear, Nose & Throat

☐ Change in Smell
☐ Change in Voice
☐ Ear Infections
☐ Ear, Throat, Facial Pain (Rate pain on a scale of 0-10 _____)
☐ Headaches
☐ Neck Mass
☐ Neck Pain (Rate pain on a scale of 0-10 _____)
☐ Nose Bleeds
☐ Problems Swallowing
☐ Ringing in Your Ears
☐ Nasal Congestion or Sinus Issues
☐ Snoring
☐ Thyroid Problems
  ☐ Do you have a family history of thyroid cancer/disease?
  ☐ Do you have a history of radiation exposure?
☐ Loss of Hearing
  ☐ Have you ever used a hearing aid?
  ☐ Do any of your family members use hearing aids?
  ☐ Do you have any loud noise exposure?
  ☐ Does hearing fluctuate?
  ☐ Sudden hearing loss?
  ☐ Do you have a family history of hearing loss?
☐ Dizziness/Vertigo
  When did you first notice it? _____
  ☐ Light Headed
  ☐ Loss of Consciousness
  ☐ Loss of balance when walking
  ☐ Objects spinning or turning around you
☐ Other _____

Constitutional/General

☐ Fever
☐ Chills
☐ Unexplained Weight Loss/Gain

Eyes

☐ Change in Vision
☐ Itchy/Watery Eyes

Respiratory

☐ Cough
☐ Shortness of Breath

Cardiovascular

☐ Chest Pain or Discomfort
☐ Irregular Heart Beat/Palpitations

Gastrointestinal

☐ Indigestion or Heartburn
☐ Swallowing Difficulties

Psychological

☐ Depression
☐ Anxiety

Genitourinary

☐ Loss of Urinary Control (PQRS 48)

Skin

☐ Skin Rash/Itching

Musculoskeletal

☐ Limitation of Motion (Neck)

Hematologic/Lymphatic

☐ Swollen Glands

Other _____

ALCOHOL/DRUG USE:

Do you use alcohol? ☐ Yes ☐ No

How many drinks per week?

_____

Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No

TOBACCO USE:

☐ Current Smoker
  How much/how long? _____
☐ Chewing Tobacco
☐ Former Smoker/Date Quit _____
☐ Never Smoked

PLEASE CONTINUE ON REVERSE SIDE

MEDICAL HISTORY:

☐ Bleeding/Clotting Problems
☐ Cancer (Type: _____)
☐ Diabetes
☐ Heart Disease
☐ Hepatitis
☐ Head Injury
☐ HIV
☐ MRSA
☐ Problems with Anesthesia
☐ Other _____

PAST SURGERY: *Have you had any of the following surgeries? (Check all that apply.)*

☐ Yes ☐ No Ear Surgery
☐ Yes ☐ No Nasal/Sinus Surgery
☐ Yes ☐ No Neck Surgery
☐ Yes ☐ No Spinal Neck Surgery
☐ Yes ☐ No Throat Surgery
☐ Yes ☐ No Other Surgery: _____

FAMILY HISTORY: Has any ***member of your family*** ever had the following? If yes, indicate family member. ***Do not include spouse or in-laws.***

		Which Family Member?
☐ Yes ☐ No	Allergies	
☐ Yes ☐ No	Cancer (include type)	
☐ Yes ☐ No	Problems with Anesthesia	
☐ Yes ☐ No	Problems with Bleeding/Clotting	

SOCIAL HISTORY: *(0-12 years ONLY)*

Child's grade level _____

☐ Yes ☐ No Does your child go to day care?

☐ Yes ☐ No Is your child exposed to second hand smoke?

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐ See attached list for medications.)	Dose	Frequency

ALLERGIES: Please list any allergies.

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No

Patient/Parent Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____