Ear, Nose Throat Surgery

MEDICAL QUESTIONAIRE

PATIENT: _____

Instructions to patient: **PLEASE ANSWER ALL QUESTIONS** Please indicate by a check your answer to each question. These answers will greatly help your doctor to give you his (or her) best care. If yest do not understand any question or answer is uncertain simply place a question mark in the column.

Have you had or still have?:	NO	NOW	PAST	REMARKS	**Have you had or still have?:**	NO	NOW	PAST	REMARKS
Difficulty Hearing					Chest Pain,Angina				
Dizziness					Heart Attack (s)				
Ringing in the Ear					Palpitations/irregular/fast heart beat				
Ear Pain					Anemia/Blood Disorders				
Facial Paralysis					Bleeding Disorders				
Headaches					Sickle Cell Illness				
					Infectious Mononucleosis				
Difficulgy breathing through nose					Jaundice, Hepatitis				
Loss of smell / taste					Liver Trouble				
Post Nasal Drip					Gallbladder Trouble				
Drainage from Nose					Back Pain or Injury				
Pressure behind the eyes					Ulcer Disease				
Facial Discomfort					Bleeding from Stomach				
Snoring					Stroke				
					Seizures				
Pain / Swelling with Meals					Thyroid Trouble				
Pain with Chewing					Diabetes				
Clicks / Popping in Jaw Joints					Low Blood Sugar				
Orthodontic Treatment-braces					Kidney Trouble				
Chronic Sore Throats					Joints Replaced with Prosthesis				
Difficulty Swallowing									
Lump in the Throat									
Persisting Hoarsness/ Voice Change					Are you running a fever?				
Lump in the Head/Neck Area					If female, are you pregnant?				
Facial Injuries					What operations have you had?				
Auto Accident Injury									
Whiplash Injury									
Bronchitis, a chronic cough									
Asthma									
Allergy Treatment or Shots					Have you had blood transfusion?				
Hay Fever					Any history of cancer or other				
Pneumonia					disease in your family?				
Tuberculosis					Have you or your family had an				
Emphysema					unusual reaction to anesthesia?				
Shortness of Breath					either local or general?				
Any Other Lung Trouble					Are you taking medications (or recently took)?				
					blood pressure				
Rheumatic Fever					diuretic (water pills)				
Heart Disease					anti depresants				
Heart Murmur/Mitral Valve Prolapse					tranquilizers				
High Blood Pressure					blood thinners				
Low Blood Pressure					eye drops				
					pain pills, or shots				
A Sexually Transmitted Disease					steroids, cortisol, A.C.T.H.				
High Risk for AIDS or Hepatitis					diabetic medication				
AIDS or HIV					sleeping tablets				
					Birth Control Pills				
					Other				

Do you **NOW**, or have you **EVER**, smoked cigarettes? ___Yes ___ No If so, how much?_____ Quit, when? _____

Do you drink beer, or other alcoholic beverages? ___ Yes ___ No If so, how much?_____ Quit, when? _____

Signature of Person Filling Out Form _____ Date: _____