

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>): _____		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor: _____		Primary care Physician (PCP): _____	
Preferred Pharmacy: _____			
Employment status:	<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired Occupation: _____		
Race & ethnicity:	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other: _____		
Language preference:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
How did you hear about us? <input type="checkbox"/> Internet Search <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Advertisement <input type="checkbox"/> Other: _____			
Has any member of your family been seen by any of the physicians at River ENT? If yes, specify:			
Reason for today's visit:			

PATIENT HEALTH HISTORY

PAST MEDICAL HISTORY

<input type="checkbox"/> Allergy Testing	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Laryngitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heartburn (reflux)	<input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure (hypertension)	<input type="checkbox"/> Pharyngitis
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> High Cholesterol (hyperlipidemia)	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Human Immunodeficiency Virus (HIV)	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Cancer, type: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Thyroid Disorder
If treated, how: _____	_____	<input type="checkbox"/> Vertigo/Dizziness

PAST SURGICAL HISTORY

Year	Reason	Hospital

FAMILY HEALTH HISTORY

Relation to Patient	Medical Condition

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Children Only (under 17 years of age)	Are immunizations up to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Gestation?	_____ weeks	
	Pregnancy or Perinatal Problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a history of neonatal ICU (NICU) stay at time of birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, for what reason?		
	Is there a history of smoke exposure, including secondary smoke exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Patient Name: _____ Date of Birth: _____ Date of Service: _____

REVIEW OF SYSTEMS - Are you currently having problems with: (check all that apply)		
General	Cardiovascular	Neurological
<input type="checkbox"/> Fever	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Chills	<input type="checkbox"/> Palpitations (fast heart beat)	<input type="checkbox"/> Numbness
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Lower Extremity Swelling	<input type="checkbox"/> Fainting
<input type="checkbox"/> Feeling Tired (Fatigue)	Respiratory	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Recent Weight Gain	<input type="checkbox"/> Difficulty Breathing	Psychiatric
<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Depression
Eyes	<input type="checkbox"/> Cough	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Snoring	Endocrine
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Bloody Sputum	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Discharge from Eyes	Gastrointestinal	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Eyes Itch	<input type="checkbox"/> Nausea	Hematological/Lymphatic
Ear, Nose, Throat	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Nosebleeds	Skin	
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Rash	
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Skin Lesion Change	<input type="checkbox"/> ***None***

I certify that the information in this document is, to my knowledge, accurate.

Signature of patient or responsible party

Print name of patient or responsible party

Date

