RiverENT
Adult & Pediatric Ear, Nose & Throat Specialists

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 (Last, First, M.I.): ☐ M ☐ F ☐ Other	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Primary care physician (PCP):**
Preferred pharmacy:	
Employment status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Occupation: _____	
Race & ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Hispanic or Latino ☐ Other: _____	
Language preference: ☐ English ☐ Spanish ☐ Other:_____	
How did you hear about us? ☐ Internet Search ☐ Family Member ☐ Friend ☐ Physician ☐ Advertisement ☐ 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

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

PAST SURGERY 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?		☐ Yes	☐ No
	☐ Cigarettes packs/day	☐ Chew #/day	☐ Pipe #/day	☐ Cigars #/day
	☐ # of years	☐ Or year quit		
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Immunizations	Are immunizations up-to-date?		☐ Yes	☐ No
For Children Only (under 17 years of age)	Gestation?		weeks	
	Pregnancy or perinatal problems?		☐ Yes	☐ No
	Is there a history of neonatal ICU (NICU) stay at the time of birth?		☐ Yes	☐ No
	If yes, for what reason?			
	Is there a history of smoke exposure, including secondary smoke exposure?		☐ Yes	☐ No
	Did the child pass a newborn hearing screening?		☐ Yes	☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name of Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name of Drug	Reaction You Had