**ENT SUPPLEMENTAL MEDICAL QUESTIONNAIRE**

**Relationship to Patient:** ___________________________  **Today’s Date (mm/dd/yyyy):** _____/ _____/ ________

**Pharmacy:** ___________________________  **Height:** __________  **Weight:** __________

**Location:** ___________________________  **Dominant Hand:** [ ] Left  [ ] Right

**Allergies to medications:** *(Please note your allergies & reactions, or select "NONE")*

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<th>[ ] None</th>
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**Reactions:**

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**Medications & Supplements:** *(Include vitamins and over the counter medications)*

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<th>[ ] None</th>
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**Dosage:**

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**Medical Problem History:** *(Please list current and past medical history)*

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**Social History:**

<table>
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<tr>
<th>Smoker?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
<th>If yes, how many packs per day? ________</th>
<th>How long? ________</th>
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<tr>
<td>Former Smoker?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>If yes, how many packs per day? ________</td>
<td>How long? ________</td>
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<td>Drug Use?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>What type of drugs used? ________</td>
<td>Former Drug User? [ ] Yes  [ ] No</td>
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<tr>
<td>Alcohol?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>If yes, how often? [ ] 0-2 Drinks Per Day  [ ] 2+ Drinks Per Day  [ ] Weekly  [ ] Monthly / Special Occasions</td>
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**Family Medical History:**

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**For Females Only:**

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<tr>
<th>Date of LMP: _____/ _____/ ________</th>
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<tr>
<th>Are you pregnant? [ ] Yes  [ ] No</th>
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## ENT SUPPLEMENTAL MEDICAL QUESTIONNAIRE (continued...)

### Supplemental Surgical History

- Appendectomy
- Adenoidectomy
- Sinus Surgery
- Tonsillectomy
- Tympanostomy (Tubes)

**List other surgeries:**

### Review of Systems

#### CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS

#### GENERAL SYMPTOMS
- Appetite Change
- Increased Appetite
- Body Ache
- Chills
- Daytime Sleepiness
- Excessive Sweating
- Fatigue
- Fever
- Headaches
- Lethargy
- Malaise
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

#### EYES
- Blind Spots
- Blurred Vision
- Change in Vision
- Corrective Lens / Glasses
- Decreased Night Vision
- Diplopia
- Dry Eyes
- Eye Discharge
- Eye Irritation
- Eye Pain
- Floaters
- Itchy Eyes
- Peripheral Vision Loss
- Photophobia
- Seeing Flashes
- Spots in Vision
- Tunnel Vision
- Visual Disturbances
- Vision Loss

#### EAR/NOSE/THROAT
- Abnormal Hearing
- Bleeding Gums
- Change in Voice
- Dental Pain
- Dental Problems
- Disequilibrium
- Dizziness/Vertigo
- Dry Mouth
- Dysphagia
- Ear Discharge
- Ear Pain
- Epistaxis
- Facial Pain
- Halitosis
- Headaches
- Hearing Loss
- Hoarseness
- Lip Swelling
- Mouth Lesions
- Mouth Pain
- Nasal Congestion
- Nasal Discharge
- Nasal Obstruction
- Nasal Trauma
- Neck Mass
- Neck Pain
- Nose Pain
- Odynophagia
- Otalgia
- Postnasal Drip
- Sinus Pain
- Sinus Pressure
- Sore Throat
- Throat Swelling

#### EAR/NOSE/THROAT (cont.)
- Tinnitus
- Tongue Swelling

#### CARDIOVASCULAR
- Chest Pain
- At Rest
- With Activity
- Claudication
- Difficulty Breathing
  - When Laying
  - With Activity
- Dyspnea
  - On Exertion
  - Paroxysmal Nocturnal
- Edema
  - Leg Edema
  - Pedal Edema
  - Peripheral Edema
- Lightheadedness
- Radiating Jaw, Neck, or Arm Pain
- Palpitations
- Diaphoresis
- Orthopnea
- Rapid Heart Rate
- Slow Heart Rate
- Leg Ulcers
- Syncope

#### RESPIRATORY
- Change in Phlegm Color
- Chest Congestion
- Cough
- Dysnea / Difficulty Breathing
  - During Activity
  - On Exertion
  - Sleeping / Nighttime
  - While Laying
- Hemoptysis
- Pain on Inspiration
- Pain with Cough
- Shortness of Breath
- Sleep Apnea
- Snoring
- Sputum Production
- Stridor
- Wheezing

#### GASTROINTESTINAL
- Abdominal Pain
- Belching
- Black Stools
- Bloody Stools
- Bloating
- Change in Bowel Habits
- Change in Stool Color
- Constipation
- Cramping
- Diarrhea
- Dyspepsia
- Dysphagia
- Early Satiety
- Excessive Flatus
- Fecal Incontinence
- Food Intolerance
- Hematemesis
- Hematochezia
- Loose Stools
- Melena
- Nausea
- Odynophagia
- Reflux/Heartburn
- Tenesmus
- Vomiting

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**Patient Name: ___________________________**

**Birthdate: ___________________________**

**Official use only: MRN#: __________ Account #: __________**

Page 2
CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS

**GENITOURINARY**
- Abnormal Menses
- Abnormal Vaginal Bleeding
- Amenorrhea
- Breast Mass
- Breast Pain
- Breast Skin Changes
- Breast Swelling
- Change in Breast Shape
- Change in Libido
- Difficulty Conceiving
- Difficulty Voiding
- Dysmenorrhea
- Dyspareunia
- Dysuria
- Flank Pain
- Genital Lesions
- Genital Pruritus
- Hematuria
- Hot Flashes
- Light Periods
- Menorrhagia
- Metrorrhagia
- Nipple Discharge
- Nocturia
- Pelvic Pain
- Post Void Dripping
- Prostate Symptoms
- Sexual Dysfunction
- Urinary Frequency
- Urinary Incontinence
- Urinary Urgency
- Vaginal Discharge
- Vaginal Dryness
- Vaginal Odor
- Vaginal Pruritus

**MUSKOSKELETAL**
- Abnormal Gait
- Arthralgia
- Atrophy
- Back Pain
- Deformity
- Limited Range of Motion
- Loss of Height
- Joint Pain
- Joint Swelling
- Muscle Aches
- Muscle Cramps
- Muscle Pain
- Muscle Weakness
- Myalgia
- Neck Pain
- Numbness
- Radiation Pain Into Limb
- Stiffness
- Tingling

**SKIN**
- Acne
- Alopecia
- Bleeding Lesions
- Change in Hair
- Change in Nails
- Change in Pigmentation
- Change in Lesions
- Dry Skin
- Erythema
- Furuncle
- Hirsutism
- Jaundice
- Persistent non-healing Lesions
- New Lesions
- Photosensitivity
- Pruritus
- Rash
- Hives
- Skin Pain
- Skin Ulcer
- Sores
- Striae
- Swelling
- Unusual Bruising
- Wounds

**PSYCHIATRIC (cont.)**
- Homicidal Ideation
- Hopelessness
- Irritability
- Mood Swings
- Panic Attacks
- Paranoia
- Suicidal Ideation

**ENDOCRINE**
- Change in Body Appearance
- Cold Intolerance
- Deepening of the Voice
- Excessive Sweating
- Fatigue
- Flushing
- Heat Intolerance
- Increase in ring/shoe/hat size
- Palpitations
- Polyphagia
- Polyuria
- Polydipsia

**HEMATOLOGIC/LYMPHATIC**
- Easy Bruising
- Easy Bleeding
- Lymphadenopathy

**ALLERGIC/IMMUNOLOGIC**
- Allergies
  - Environmental
  - Food
  - Seasonal
- Eczema
- Itchy Eyes
- Swelling
  - Lip
  - Throat
  - Tongue
- Wheezing
- Urticaria

**NEUROLOGIC**
- Abnormal Gait
- Abnormal Hearing
- Abnormal Movements
- Abnormal Speech
- Behavioral Changes
- Burning Sensations
- Confusion
- Convulsions
- Disequilibrium
- Dizziness
- Focal Weakness
- Frequent Falls
- Headaches
- Lack of Coordination
- Loss of Vision
- Memory Loss
- Numbness
- Other Visual Disturbances
- Paresthesia
- Radicular Pain
- Restless Leg
- Seizures
- Sensory Deficit
- Syncope
- Tingling
- Tremors
- Vertigo
- Weakness

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**Supplemental Medical History**

Select any of the following diseases you have had:
- Alcoholism
- Cancer
- Epilepsy
- Malaria
- Pneumonia
- Tuberculosis
- Anemia
- Chicken Pox
- Goiter
- Measles
- Polio
- Typhoid Fever
- Appendicitis
- Diabetes
- Heart Disease
- Mental Disorder
- Rheumatic Fever
- Venerable Infection
- Arthritis
- Diphtheria
- Influenza
- Mumps
- Scarlet Fever
- Whooping Cough

Patient Signature: X __________________________ Date: ______/____/_______ Time: __________