A department of Ka'u Hospital
East Hawaii Health Clinic
1285 Waianuenue
ENT

Patient Name: _____ Birthdate: _____

ENT SUPPLEMENTAL MEDICAL QUESTIONAIRE

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")***

	Reactions:
[ ] None	
_____	_____
_____	_____
_____	_____
_____	_____

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

	Dosage:
[ ] None	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

_____

_____

Social History:

Smoker?	[ ] Yes [ ] No	If yes, how many packs per day? _____	How long? _____
Former Smoker?	[ ] Yes [ ] No	If yes, how many packs per day? _____	How long? _____
Drug Use?	[ ] Yes [ ] No	What type of drugs used? _____	Former Drug User? [ ] Yes [ ] No
Alcohol?	[ ] Yes [ ] No	If yes, how often? [ ] 0-2 Drinks Per Day [ ] 2+ Drinks Per Day [ ] Weekly [ ] Monthly / Special Occasions	

Family Medical History:

_____

_____

For Females Only:

Date of LMP: ____/ ____/ _____

Are you pregnant? [ ] Yes [ ] No

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ENT SUPPLEMENTAL MEDICAL QUESTIONAIRE (*continued...*)

Supplemental Surgical History

Surgeries:

☐ 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
- ☐ Dyspnea / 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: _____

ENT SUPPLEMENTAL MEDICAL QUESTIONAIRE (*continued...*)

Review of Systems (*continued...*)

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
- ☐ Prolapse Symptoms
- ☐ Sexual Dysfunction
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Urgency
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Vaginal Odor
- ☐ Vaginal Pruritus

MUSKOLOSKELETAL
- ☐ 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
- ☐ Abnormal Sleep Pattern
- ☐ Anxiety
- ☐ Behavioral Changes
- ☐ Change in Appetite
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty Concentration
- ☐ Hallucinations
  - ☐ Auditory
  - ☐ Tactile
  - ☐ Visual
- ☐ Memory Loss

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/LYMPATHIC
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Lymphadenopathy

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

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
- ☐

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	☐ Venereal Infection
☐ Arthritis	☐ Diphtheria	☐ Influenza	☐ Mumps	☐ Scarlet Fever	☐ Whooping Cough

Patient Signature: *X*_____ Date: _____/ _____/ _____ Time: _____

Official use only: MRN#: _____ Account #: _____