____ Yr. Old M / F

ENT Questionnaire

W: _____ H: _____

Temp: _____ B/P: _____

Name _____ Date _____ Chart # _____

Why are you seeing us today: *How long?* _____

Describe your present
Problem (s) or symptom (s) ➡

In each section below, please fill in any blank line and circle any symptom that is either a recent problem (within the last 6 months) or is a continuing problem.

Facial Area:

Numbness Muscle weakness Itchy eyes Watery eyes Migraines

☐ *Check, if none*

Frequent headaches Growths or skin cancer of: Face Neck Scalp

Pain in: Nose Cheek Forehead Eyes Neck Top of head Temples

Nose/Sinuses:

Drainage: Recent Persistent *How long?* _____

☐ *Check, if none*

Comes out nostrils Goes down throat

Color of drainage is: Clear Yellow Green Other: _____

Blocked Breathing: Right Left Recent Persistent *How long?* _____

Sneeze several times in a row "Hay fever" Itch Broken nose in past

Mouth:

Pain Bad teeth Growths or tumors Mouth Breather

☐ *Check, if none*

Sores or Ulcers: Recent Recurrent Persistent *How long?* _____

Throat/Neck:

Tonsillitis *How many times in the past 12 months?* ____ or None # "Strep throat" _____

☐ *Check, if none*

Other throat infections Pain: Constant With swallowing

Growths or tumors Thyroid problem Sleep Apnea - CP AP

Hoarseness or change in voice: Recent Persistent *How long?* _____

Difficulty breathing in throat "Lump" feeling Trouble swallowing

Ears:

☐ *Check, if none*

Diminished Hearing Exposure to loud sounds: In past Presently

Amount of loss in right ear: Slight Moderate Severe *How long?* _____

Amount of loss in left ear: Slight Moderate Severe *How long?* _____

Infection - *How many times in last 12 months?* _____

Drainage: Right Left **Color of drainage:** Clear Yellow Green Other

Pain: Right Left Throbbing Sharp Knife-like Pressure

More pain with chewing Ears Itch

Ringing or Odd Sounds: Right Left Can't localize

Often hear pulsating noises like heartbeats: Right Left Other: _____

Dizziness: Spinning Light-headed Off-balance Pass Out

When dizzy, do you have: Nausea Hearing change Louder ringing

More ear fullness Double or loss of vision

Fullness or Plugged Sensation: Right Left Use Hearing Aid

Feels like talking in a barrel: Right Left Use Q-Tips

PCP: _____

MEDICAL HISTORY

Name _____ **Date** _____ **Chart #** _____

Review of Systems: Please circle any problems or symptoms you ***now*** have or you have ***ever had***.
Fill in blank lines, if applicable. For each line, if not a problem check **"No"** column to the right.

	Disease of Symptom	No		Disease of Symptom	No
1	**Cough** ⇨ with or without sputum – How long? _____ Current or recent cold or flu (past 2 weeks)		11	Hiatal hernia Heartburn Stomach ulcers Trouble swallowing Hepatitis Diabetes	
2	**Lung disease:** ⇨ **TB Bronchitis Asthma Emphysema**		12	Fainting Unconscious spells – When? _____ Paralysis Stroke – Date: _____ Anxiety	
3	**Shortness of breath :** ⇨ **At rest Sleeping Walking Need to prop up on pillows to sleep**		13	Nephritis or Kidney disease Prostate problem	
4	Smoke packs/day: _____ #years _____ Date quit: _____		14	Treatment with: ⇨ Cortisone Prednisone Steroids	
5	Weight today [ ] lbs. Unexpected weight loss _____ Weight gain _____		15	Problems with: ⇨ Brain Spinal cord Nerves Muscles Back problems Herniated disc	
6	Alcohol use: Drinks or beers per day? _____		16	Cancer? Location _____ When? _____	
7	**Have you had a fever in the last month? How high?** _____		17	Epilepsy ⇨ Seizures Last Attack _____	
8	High blood pressure Low blood pressure		18	Tired feeling Loud snoring Throat clearing	
9	Heart problems Heart attack Rheumatic fever		19	Transfusions Bleeding disorder Porphyria	
10	Heart murmur Irregular or Rapid heartbeat Pacemaker		20	Thyroid problems Glaucoma Claustrophobic	

If any symptoms are circled above, write the # on one of the lines below with a short explanation.

_____ *Check, if none* ☐

_____

_____

_____

☐ Other: _____

Do you have any metal in your body? _____

Medications – List all medications (including nasal sprays) you are now taking. *Check, if none* ☐

Name of Medicine	Dose (mg)	How often	Name of Medicine	Dose (mg)	How often
Other medications taken in last month for present problem?					

Allergies or Bad Reactions to Medications – List medicine & the reaction (e.g. rash, hives, etc.):

_____ *Check, if none* ☐

Hospitalizations – List all hospitalizations **(other than surgery see below),** illness & year:

_____

_____ *Check, if none* ☐

Operations – List all operations & year: _____

_____ *Check, if none* ☐

Ever had any unexpected problems during or after anesthesia or surgery? ☐ Yes ☐ No	Has any family member had an unexpected problem with, or died during anesthesia or surgery? ☐ Yes ☐ No

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