Lawrence Otolaryngology Associates, LLC

Patient History Questionnaire

Patient Chart #________________

Please answer ALL questions to assist with your evaluation (continue on back of page).

Patient Name: ___________________________________ Date of Birth: ______________ Today's Date: ______________

ALLERGIES		PREVIOUS SURGERIES	
Drug Allergies: YES / NO If YES, list below:		**I have had Surgeries - Operations - Serious Illness: YES / NO** If YES, list all lifetime surgeries, operations, illness below:	
Allergy	Reaction	Year	Surgery/Operation/Serious Illness
______________	______________________	_______	____
______________	______________________	_______	____
______________	______________________	_______	____
______________	______________________	_______	____
______________	______________________	_______	____
______________	______________________	_______	____

PHARMACY AND MEDICATIONS

Preferred Pharmacy: ____

Pharmacy Name Address Phone Number

Mail Order Pharmacy: ____

Pharmacy Name Phone Number Fax Number

I am currently taking Prescription Medications, OTC Medications or Vitamins: Yes / No

If YES list ALL Medications (including over the counter medications and vitamins) doses and frequency below.

If you have a list prepared please give it to the receptionist to copy.

Medication Name	Strength	Dosage	Medication Name	Strength	Dosage

MEDICAL CARE TEAM

Please List All of your Current Physicians:

Physician Name	Specialty	City/State	Phone Number
____________________________	______________	_____________________	________________
____________________________	______________	_____________________	________________
____________________________	______________	_____________________	________________
____________________________	______________	_____________________	________________
____________________________	______________	_____________________	________________

PATIENT INFORMATION

TOBACCO	**Have you ever Smoked/Chewed Tobacco? (circle one) YES / NO**		
	How much? _______Packs per day	Since ______(yr)	Date Quit ______________
ALCOHOL	**Do you use Alcohol? (circle one) YES/ NO**		
	How much? ________ Drinks per Day/ Week/ Month		
OTHER	**Do you have an Advance Directive (circle one) YES/ NO** *If yes, fill out below:*		
	☐ DPOA – Copy on file	☐ Living Will – Copy on file	☐ DNR – Copy on file
	DPOA Name: ____________________________________		

BACKGROUND INFORMATION
(Please be as specific as possible)

Chief Complaint (why are you here?) ____

Location/site of the problem ____

Quality of the problem (e.g. Sharp or dull pain) ____

Severity of problem (e.g. mild, moderate, severe) ____

Timing/duration of problem (e.g. at night for 1 week) ____

Improving, worsening or staying the same? ____

Modifying factors (things that make it better or worse).____

Associated signs or symptoms: ____

Family History

	Father	Mother	Sibling	Grandparent
Cancer (list type)	Y / N	Y / N	Y / N	Y / N M P
Cholesterol	Y / N	Y / N	Y / N	Y / N Maternal Paternal
COPD/Emphysema	Y / N	Y / N	Y / N	Y / N Maternal Paternal
Diabetes	Y / N	Y / N	Y / N	Y / N Maternal Paternal
Hypertension	Y / N	Y / N	Y / N	Y / N Maternal Paternal
MI/Heart Disease	Y/ N	Y / N	Y / N	Y / N Maternal Paternal
Stroke	Y/ N	Y / N	Y / N	Y / N Maternal Paternal
Thyroid Disease	Y/ N	Y / N	Y / N	Y / N Maternal Paternal

Review of Current Personal Systems (check yes or no)

Constitutional	YES	NO	**Gastrointestinal**	YES	NO	**Psychiatric**	YES	NO
Recent Weight Change			Heartburn			Psychiatric Illness		
Regular Exercise			Intestinal Disorders			Feeling lonely/depressed		
Eyes			Difficulty Swallowing			Hard to Concentrate		
Decreased Vision			Hepatitis or Jaundice			Work or Family Problems		
Double Vision			**Genitourinary**			**Endocrine**		
Glaucoma			Kidney Trouble			Diabetes		
Neoplastic			Difficulty Urinating			Feel too hot/cold		
Cancer			Frequent Urination			Thyroid Problems		
Cardiovascular			**Neurological**			**Hematologic/lymphatic**		
Chest Pain			Muscle Weakness			Bleeding Tendency		
High Blood Pressure			Numbness of Fingers or Toes			Exposure to AIDS Virus		
Heart Murmur			Concussions			**ENT**		
Valve Problem			Un-coordination			Hearing loss		
Respiratory			Seizure Disorder			Frequent Colds		
Asthma			Strokes			Hoarseness		
Shortness of Breath			**Skin**			Hay fever		
Coughing up Blood			Skin Disorders / Rashes					
Wheezing								

FOR OFFICE USE ONLY		
Height:	R:	Ref. Phys:
Weight:	T:	
BP: /	Falls: Yes/ No	Dr. Initials:
P:	Date entered into PF:	Nurse Initials: