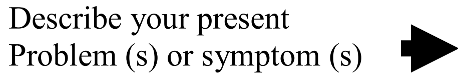
ENT Questionnaire

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:

☐ *Check, if none*

Numbness Muscle weakness Itchy eyes Watery eyes Migraines
Frequent headaches Growths or skin cancer of: Face Neck Scalp
Pain in: Nose Cheek Forehead Eyes Neck Top of head Temples

Nose/Sinuses:

☐ *Check, if none*

Drainage: Recent Persistent *How long?* ____________________
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:

☐ *Check, if none*

Pain Bad teeth Growths or tumors Mouth Breather
Sores or Ulcers: Recent Recurrent Persistent *How long?* __________________

Throat/Neck:

☐ *Check, if none*

Tonsillitis ***How many times in the past 12 months?***____or None # "Strep throat"________
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

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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