- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ CHF/Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ GERD/Heartburn/ Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Palpitations/Racing Heart
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other _____ _____

- ☐ No surgery
- ☐ Anesthesia Complications
- ☐

Name (Last, First M.I.) _____

Date of Birth (Month/Day/Year) _____

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Otolaryngology History

Reason for today's visit? _____

What treatment have you received for this? _____

Check all sympoms that apply.

- ☐ Fevers
- ☐ Chills
- ☐ Weight Loss
- ☐ Tired
- ☐ Rash
- ☐ Itching
- ☐ Headaches
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Sneezing
- ☐ Light Sensitivity
- ☐ Sore Throat
- ☐ Hoarse Voice
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Runny Nose
- ☐ Stuffy Nose
- ☐ Sinus Pain
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Blurry Vision
- ☐ Watery, Itchy Eyes
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Chest Pain
- ☐ Muscle Aches
- ☐ Heartburn
- ☐ Upset Stomach
- ☐ Gland Swelling
- ☐ Tremor
- ☐ Depression
- ☐ Nervousness/Anxiety
- ☐ Daytime Sleepiness
- ☐ Numbness

Does anyone in your family have hearing loss? ☐ Yes ☐ No

If yes, how are they related? ☐ Parent ☐ Grandparent ☐ Sibling ☐ Children ☐ Aunt ☐ Uncle ☐ Cousin ☐ Other

Is there any other information you would like us to know?