

**Lawrence Otolaryngology  
Patient History Questionnaire**

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**PLEASE FILL IN SPACES AND ANSWER/CIRCLE ALL OF THE FOLLOWING QUESTIONS**

**All information must be filled out completely prior to appointment**

**Drug Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List previous Operations and Dates**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Serious Illnesses and approximate Dates:**

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever Smoked/Chewed Tobacco? (Circle one) YES / NO**

How Much \_\_\_\_\_ Date Quit: \_\_\_\_\_

**Do you use Alcohol?(Circle one) YES / NO** How Much? \_\_\_\_\_

List any diseases that run in your family (such as cancer, diabetes, thyroid diseases etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Do you have an Advance Directive? (Circle one) YES / NO**

(eg. Living Will, Durable Power of Attorney or a Health Care Proxy)

**REVIEW OF CURRENT PERSONAL SYSTEMS (circle either yes or no)**

**Constitutional**

Recent weight change Yes No  
Regular exercise Yes No

**Eyes**

Decreased vision Yes No  
Double vision Yes No  
Glaucoma Yes No

**Neoplastic**

Cancer Yes No

**Cardiovascular**

Chest Pain Yes No  
High blood pressure Yes No  
Heart murmur Yes No  
Valve problem Yes No

**Respiratory**

Asthma Yes No  
Shortness of breath Yes No  
Coughing up blood Yes No  
Wheezing Yes No

**Gastrointestinal**

Heartburn Yes No  
Intestinal disorders Yes No  
Difficulty swallowing Yes No  
Hepatitis or jaundice Yes No

**Genitourinary**

Kidney trouble Yes No  
Difficulty urinating Yes No  
Frequent urination Yes No

**Neurological**

Muscle weakness Yes No  
Numbness of fingers or toes Yes No  
Concussions Yes No  
Uncoordination Yes No  
Seizure disorder Yes No  
Strokes Yes No

**Skin**

Skin disorders/rashes Yes No

**Psychiatric**

Psychiatric illness Yes No  
Feel lonely or depressed Yes No  
Hard to concentrate Yes No  
Work or family problems Yes No

**Endocrine**

Diabetes Yes No  
Feel too hot or cold Yes No  
Thyroid problems Yes No

**Hematologic/lymphatic**

Bleeding tendency Yes No  
Exposure to AIDS virus Yes No

**ENT**

Hearing loss Yes No  
Frequent colds Yes No  
Hoarseness Yes No  
Hay fever Yes No

**FOR OFFICE USE ONLY**

Date \_\_\_\_\_  
Ref Phy \_\_\_\_\_  
Nurse Initial's \_\_\_\_\_  
Dr. Initial's \_\_\_\_\_

Date \_\_\_\_\_  
Ref Phy \_\_\_\_\_  
Nurse Initial's \_\_\_\_\_  
Dr. Initial's \_\_\_\_\_

Date \_\_\_\_\_  
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Dr. Initial's \_\_\_\_\_

