UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Otolaryngology **Health History Questionnaire- New Patient - Otolaryngology**	NAME: MRN: BIRTHDATE: AGE:

Please fill this form out as completely as possible and bring this to your appointment.

Date of Appointment: _____/_____/_____ (mm/dd/yyyy)

If you are an existing patient to the University of Michigan Hospital and Health Centers, you may skip the medication list and allergies/adverse reactions sections below. You will be given a printed list of medications and allergies which you will edit when you arrive at the clinic.

What is the reason for your visit (chief complaint)? _____

What is your most recent occupation (if age 18 years or older)? _____

Medication List

Please list the names of any medications that you are currently taking below. Please indicate the correct dosage and frequency (if known). Include supplements, herbals and over the counter medications. If you are unsure, ask your clinician.

Medication Name	Dose / Frequency (How often taken)	Refills Needed? If yes, circle the days supply
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90
	/	30 / 90

Please indicate any non-medication prescriptions for which you need refills (such as supplies):

_____

Allergies / Adverse Reactions

Please indicate any medications, foods, etc. to which you have had an allergic or bad reaction.

What are you allergic to?	What happened when you took or used it?

Past Medical History (Check any medical problems you have had)**:**

- ☐ Anxiety
- ☐ Arrhythmia(Palpitations)
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic lung disease
- ☐ Cirrhosis
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Deep vein thrombosis
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ MI (Heart attack)
- ☐ Pulmonary embolism
- ☐ Seizures
- ☐ Skin cancer
- ☐ Stroke
- ☐ Substance abuse
- ☐ Syncope (Fainting)
- ☐ Thyroid disease

Other (specify): _____

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Past Surgical History (Check any surgeries you have had and state date of surgery if you know it)**:**

- ☐ Adenoidectomy
- ☐ Brain surgery
- ☐ CABG (Heart bypass)
- ☐ Cholecystectomy (Gall bladder removal)
- ☐ Facial cosmetic surgery
- ☐ Facial fracture surgery
- ☐ Heart surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Radiation therapy
- ☐ Sinus surgery
- ☐ Tonsillectomy
- ☐ Valve replacement

Other (specify): _____

Family History

Check below to report problems your family members have had. Please state age when they had problem, if you know it.

☐ I was adopted. So, I don't know my family history.

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Bleeding disorder							
Clotting disorder							
Hearing loss							
Heart disease (<45 years old)							
Cancer (what type?)							
Other (specify):							
Alive? (Yes, No or N/A=Not applicable)							

Social History

Do you ever drink alcohol? ☐ Yes ☐ No

If yes, please indicate the quantity per week of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz of alcohol _____

Check one of the following about smoking tobacco:

- ☐ Never smoked
- ☐ Former smoker
- ☐ Smoke some days
- ☐ Smoke every day
- ☐ Exposed to second hand smoke

If you do smoke or used to smoke, how many packs do/did you smoke per day? _____

How many years did you smoke/have you smoked? _____

If you quit, when did you quit? _____

Do you use "smokeless tobacco?" (select one below)

- ☐ Former user
- ☐ Current user
- ☐ Never used

If you quit, when did you quit? _____

Are you ready to quit smoking and/or using smokeless tobacco? ☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No

If you use drugs, how many times per week: _____

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Review of Systems Please circle any current problems/symptoms:

Constitutional	anorexia (eating disorder, significantly decreased food intake); chills; fatigue; fevers; malaise (not feeling quite right); night sweats; sweats; weight loss
Eyes	diplopia (double vision); lid erythema (redness); lid edema (swelling); conjunctival redness (red eye); visual disturbance
Ears, nose, mouth, throat and face	otalgia (ear pain); otorrhea (ear drainage); hearing loss; worse nasal obstruction; purulent rhinorrhea (pus-like nasal drainage); recurring nosebleeds; snoring; throat pain; voice change; dysphagia (trouble swallowing)
Respiratory	asthma; chronic bronchitis; cough; emphysema; hemoptysis (coughing up blood); pneumonia; shortness of breath; stridor (noisy high pitched breathing); wheezing (noisy breathing with hoarse whistling sound)
Cardiovascular	cardiac disease; myocardial infarction (heart attack); chest pain; chest pressure/discomfort; dyspnea on exertion (shortness of breath with activity); irregular heart beat; lower extremity edema (swelling); orthopnea (trouble breathing unless sitting or standing up straight); syncope (fainting)
Gastrointestinal	ulcer disease; reflux symptoms (heartburn); dysphagia (trouble swallowing); hepatitis; liver disease; vomiting; diarrhea
Genitourinary	kidney disease; nocturia (getting up often at night to urinate); urinary frequency
Skin / breast	skin lesion(s)
Blood / lymph	bleeding disorders; easy bruising; clotting disorders; blood clots; lymphadenopathy (swollen lymph nodes)
Musculoskeletal	rheumatoid arthritis; arthralgias (joint pains) ; autoimmune disease; bone pain
Neurological	stroke; seizures; weakness; numbness; paresthesias (burning or prickling sensation); speech problems; vertigo (dizziness)
Behavioral / Psychological	anxiety; depression; excessive alcohol consumption; recreational drug usage
Endocrine	thyroid disease; cold intolerance; dry skin; diabetes; polydipsia (excessive thirst); polyphagia (excessive hunger); polyuria (excessive production or passage of urine); poor wound healing
Allergic / Immunologic	allergic rhinitis (hay fever); anaphylaxis (severe allergic reaction with trouble breathing); autoimmune disorders (i.e. lupus, rheumatoid arthritis); immunosuppressive drugs

_____ _____/_____/_____

Printed Name of Person filling out this form Date (mm/dd/yyyy)

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