

New Patient Questionnaire- Adult

Patient Name: _____ DOB: _____

Were you sent to our office by another physician? YES NO

If yes, NAME of referring physician _____

Who is your primary care physician? _____

What are you here to see the doctor about today? _____

How long has this problem been present? _____

Does anything make the problem better or worse? _____

Is the problem improving? Worsening? Staying the same? _____

ENT REVIEW	NO	YES	GENERAL REVIEW	NO	YES	IF YES, EXPLAIN
Difficulty Breathing			Fever/ Chills/Weight Changes			
Nasal Bleeding			Eyes (vision change, pain, double vision)			
Nasal blockage			Heart (chest pain, palpitations)			
Snoring			GI (stomach pain, nausea, diarrhea)			
Ear Pain /Drainage			Musculoskeletal (muscles, joints, pain, weakness)			
Change in Hearing			Endocrine (thyroid, hot flashes, cold/heat intolerance)			
Sore Throat			Hematologic (blood, lymph nodes)			
Voice Changes			Integument (skin, rashes)			
Throat Clearing			Neurological (headaches, nerve pain, weakness)			
Facial Pain/ Pressure			Allergy (seasonal allergies)			
Heartburn			Psychiatric			
Runny Nose						

Medical History

List Medications: (none)

Allergies to Medications: (none)

List Surgeries (please list if you have had any ear, nose or throat surgeries, including sinus nasal, tonsils, or adenoid surgery) (none)

Medical Problems	NO	YES	Family History	NO	YES
Asthma			Bleeding disorder		
Lung disease			Anesthesia reaction		
Thyroid disease			Hearing loss		
Heart disease			Diabetes		
High blood pressure			Heart Disease		
Bleeding disorder			Cancer? Type:		
HIV or AIDS					
Sickle Cell Disease			Social History		
Hepatitis			Do you smoke or use tobacco?		
Diabetes			Do you use alcohol?		
GERD			Do you use any drugs, such as marijuana, heroin, cocaine?		
Cancer? Type:			Other Illness? Please list:		

What is your marital status? Single Married Divorced Widowed

What is your occupation?

(Signature of Patient or Guardian)

(Date)

Physician Review: _____ Date _____
