STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

Addressograph Stamp - Patient Name, Medical Record Number

PROGRESS NOTES • ENT CLINIC • PATIENT QUESTIONNAIRE

Date: _____

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit? _____
2. How long have you had this problem? _____
3. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10
   mild very severe
4. How often does this problem occur? ☐ constant ☐ comes and goes
5. What makes it better? _____
6. What makes it worse? _____
7. What other symptoms are you having? _____

PAST MEDICAL HISTORY (Please check any illnesses you have):

☐ High blood pressure
☐ Kidney disease
☐ Diabetes
☐ Neck/Back disease
☐ Asthma/Emphysema
☐ Stroke, mini-stroke
☐ Heart disease/Angina
☐ Hepatitis/Liver disease
☐ Rheumatic fever
☐ Sinusitis
☐ Peptic ulcers
☐ Thyroid disease
Others: _____ _____ _____
☐ Cancer (please list type and date diagnosed): _____

PAST SURGICAL HISTORY (Please check any surgeries you have had):

☐ Heart bypass/valve
☐ Coronary angioplasty
☐ Carotid artery surgery
☐ Vascular bypass
☐ Mastectomy
☐ Heart transplant
☐ Gall bladder
☐ Lung surgery
☐ Joint replacement
☐ Back surgery
☐ Brain surgery
☐ Liver transplant
☐ Prostate removal
☐ Colon removal
☐ Appendix removal
☐ Sinus surgery
☐ Tonsillectomy
☐ Kidney transplant
Others: _____ _____ _____ _____ _____ _____

MEDICATIONS (List all your current medications and the dose you take):

Medication _____ Dose _____
Medication _____ Dose _____
Medication _____ Dose _____
Medication _____ Dose _____

Do you take Aspirin or Ibuprofen? ☐ Yes ☐ No
Do you take Warfarin (Coumadin)? ☐ Yes ☐ No
Have you taken steroids within the past year? ☐ Yes ☐ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):

Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____

FAMILY HISTORY (Check all illnesses that run in your family):

☐ Hearing loss
☐ High blood pressure
☐ Sickle cell anemia
☐ Poor circulation
☐ Alcoholism
☐ Psychiatric illness
☐ Bleeding problems
☐ Anesthesia reaction
☐ Heart attack
☐ Cancer
☐ Diabetes
☐ Stroke
Others _____ _____ _____ _____

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SOCIAL HISTORY:

Occupation _____ Marital status: ❑ Married ❑ Single ❑ Divorced
How many children do you have? _____
Have you ever smoked? ❑ Yes ❑ No (❑ cigarettes, ❑ cigar, ❑ pipe)
How much, and for how long have you smoked? _____ packs per day for ____ years.
How much alcohol do you drink each day? _____
List any street drugs you currently use: _____
Do you have any drug addictions? ❑ Yes ❑ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

❑ Weight loss _____ pounds in the past _____ weeks ❑ Fever, chills

EYES:

❑ Double vision
❑ Loss of vision
❑ Eye pain

ENT:

❑ Hearing loss
❑ Ringing in ears
❑ Dizziness
❑ Ear pain
❑ Ear drainage
❑ Nose drainage
❑ Nasal congestion
❑ Facial pain
❑ Headaches
❑ Sore mouth/throat
❑ Swallowing pain
❑ Voice change
❑ Snoring
❑ Hoarseness
❑ Poor sleep

CARDIOVASCULAR/PULMONARY:

❑ Chest pain
❑ Poor circulation
❑ Shortness of breath
❑ Heart attack
❑ Leg pain during walking
❑ Asthma
❑ Irregular heartbeat
❑ Coughing up blood

GASTROINTESTINAL:

❑ Stomach ulcers
❑ Blood in stool
❑ Nausea/vomiting
❑ Trouble swallowing
❑ Diarrhea
❑ Abdominal pain

GENITOURINARY:

❑ Blood in urine
❑ Pain during urination
❑ Difficulty making urine

MUSCULOSKELETAL:

❑ Neck/Spine surgery
❑ Neck or Back disorder
❑ Arthritis

NEUROLOGICAL:

❑ Stroke
❑ Loss of sensation
❑ Ministroke
❑ Paralysis of an arm or leg
❑ Temporary loss of vision or speech control
❑ Facial paralysis

SKIN:

❑ Skin cancers
❑ Allergy to medical tape, iodine, or latex

PSYCHIATRIC:

❑ Clinical depression
❑ Hallucinations
❑ Schizophrenia
❑ Other psychiatric disorder (list) _____
❑ Anxiety

INFECTIOUS DISEASE:

❑ Hepatitis
❑ TB
❑ HIV/AIDS
❑ Mononucleosis

I have personally reviewed this history and review of systems:

_____ _____
Attending Physician Signature Date