Patient Health and History Questionnaire

Patient Name:_____**DOB:**_____**Signature:**_____

Height:_____ **Weight:**_____

Social History (Check all that apply)

Alcohol:	☐ Never	☐ Occasional	☐ Moderate	☐ Daily
Tobacco:	☐ Never	☐ Former	☐ <1 pack/day	☐ >1pack/day
Chewing Tobacco:	☐ Never	☐ Former	☐ Current	
Cigars:	☐ Never	☐ Former	☐ Occasional	☐ Regular

Personal Illnesses (Check all that apply)

☐ High Blood Pressure ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer

☐ Diabetes ☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis ☐ Reflux

☐ Kidney Problems ☐ Liver Disease ☐ Lung Disease ☐ Thyroid Disease

☐ Autoimmune Disorder ☐ Stroke ☐ Sexually Transmitted Disease

☐ Environmental Allergy Other:_____

Family History/Illnesses (Check all that apply)

☐ Adverse Reaction to Anesthesia ☐ Bleeding Disorder ☐ Cancer (Mother's Side)

☐ Cancer (Father's Side) ☐ Diabetes ☐ Heart Disease

☐ Head/Neck Cancer (Mother's Side) ☐ Head/Neck Cancer (Father's Side)

Other:_____

Previous Personal Surgeries (Check all that apply)

☐ Pacemaker ☐ Heart Surgery ☐ Valve Replacement ☐ Joint Surgery ☐ Tonsils

☐ Adenoids ☐ Ear Tubes ☐ Other Ear Surgery ☐ Sinus Surgery ☐ Nasal Surgery

☐ Lung Surgery ☐ Thyroid Surgery ☐ Other Head/Neck Surgery

Other Surgery:_____

Review of Systems (Check all that apply)

☐ Migraine ☐ Anxiety/Depression ☐ History of Radiation Exposure

(over)

Patient Health and History Questionnaire

Patient Name:_____

Medication History

Preferred Pharmacy:_____

List all known drug allergies. Write "NONE" if no known drug allergies exist.

_____

_____

_____

Medication Name	Dose	#Times Taken/Day