Health Questionnaire

Department of Otolaryngology
1625 Medical Center Point, Suite 200, Colorado Springs, CO 80907

DaVita Medical Group

Patient Name_____ Today's Date_____

Patient's Date of Birth_____ Age_____ MRN_____

This questionnaire is used to gain information to assist in providing you or your family with the best possible care. Please answer the questions to the best of your ability. Some of the questions may not apply to every patient or may apply to your child if he/she is to have surgery. Any questions you have about the survey should be brought up during your visit with the physician.

Previous Medical History:

Medical Problems *(please list all medical problems or conditions, both current and past):*

_____

_____

_____

Circle all that apply:

Diabetes	High Blood Pressure	Stroke	Allergies (Seasonal / Food)
High cholesterol	Asthma	Coronary artery disease	Emphysema/COPD
Thyroid disease	GERD	Easy bruising/bleeding	Cancer: _____
Immune problems	Immunosuppression	Ear tubes	Skin cancer removal
Tonsillectomy	Ear surgery	Sinus surgery	Nasal surgery Neck surgery

Previous Surgeries:

Surgery	Date
_____	_____
_____	_____
_____	_____

Current Medications *(please include prescriptions, over-the-counter, vitamins and/or herbals):*

Name:	Strength:	How Taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies *(Are you allergic to, or have you had a "bad reaction" to any medicines or substances?):*

□ **No** □ **Yes** If yes, please list the medications and the reactions:

_____

Continued next page

Social History:

Marital Status: _____ Occupation: _____

Cigarettes/Cigars/Pipe: ◻ No ◻ Yes Amount per week: _____ per day: _____

Age at start:_____ Duration of smoking: _____ If quit, when? _____

Smokeless Tobacco (chew) ◻ No ◻ Yes Amount per week: _____ per day: _____

Use of alcohol (beer/wine/liquor)? ◻ No ◻ Yes Amount per week: _____ per day: _____

Use of recreational or intravenous drugs? ◻ No ◻ Yes If yes, please list: _____

For children:	**Are there smokers in the household?**	**◻ No**	**◻ Yes**	
	Does your child attend day care/school?	**◻ No**	**◻ Yes**	**Grade in school: _____**
	Are his/her immunizations up to date?	**◻ No**	**◻ Yes**	
	Any problems with pregnancy or delivery?	**◻ No**	**◻ Yes**	

Family History: *(please circle any condition below that any blood relative has had.)*

Condition	Relative	Condition	Relative	Condition	Relative
Heart attack	_____	Prostate cancer	_____	Rheumatoid arthritis	_____
High blood pressure	_____	Melanoma	_____	Alcoholism	_____
High cholesterol	_____	Emphysema/COPD	_____	Hepatitis	_____
Stroke	_____	Asthma	_____	Cirrhosis	_____
Breast cancer	_____	Tuberculosis	_____	Anemia (low blood)	_____
Colon cancer	_____	Thyroid problems	_____	Easy bleeding/bruising	_____
Head & neck cancer	_____	Autoimmune disease	_____	Cancer (other)	_____
Diabetes	_____	Blood clots	_____		

Review of Systems *(please place a check mark next to any symptoms you CURRENTLY have):*

General
- ☐ Change in Appetite
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Weight Loss- Unexplained
- ☐ Change in Sleep
- ☐ Anemia

Ear, Nose, Throat
- ☐ Ringing In The Ears
- ☐ Hearing Difficulties
- ☐ Ear Pain
- ☐ Runny Nose/ Cong./Obstruc
- ☐ Loss of Smell
- ☐ Nose Bleeds
- ☐ Facial Pain/Pressure
- ☐ Dental Pain/Mouth Sores
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Nasal Obstruction

Eye
- ☐ Eye Pain
- ☐ Blurry/Double Vision
- ☐ Loss of Vision
- ☐ Flashing Lights

Cardiovascular/ Heart
- ☐ Chest Pain/ Pressure
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Difficulty Laying Flat
- ☐ Leg Swelling
- ☐ Blood Clots
- ☐ Irregular Heartbeat
- ☐ Heart Disease

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting
- ☐ Yellow Skin Or Eyes
- ☐ Abdominal Pain
- ☐ Black/Bloody Stool
- ☐ Ulcers
- ☐ Excessive Gas/Bloating

Respiratory/ Lung
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness Of Breath
- ☐ Snoring
- ☐ Sleep Apneas

Mental Health
- ☐ Anxiety/Depression
- ☐ Difficulty Sleeping
- ☐ Mood Swings
- ☐ Chronic Fatigue
- ☐ Difficulty Concentrating
- ☐ Panic Attacks
- ☐ Stress; Severe

Neurological
- ☐ Dizziness
- ☐ Numbness/Tingling
- ☐ Loss of Strength
- ☐ Migraines/Headaches
- ☐ Memory Loss
- ☐ Tremors
- ☐ Seizure Activity
- ☐ Headache- Severe

Hematology/Lymphatic
- ☐ Easy Bruising
- ☐ Gums Bleed Easily
- ☐ Enlarged/Tender Lymph Noteds

Allergy/Immunologic
- ☐ Hives/Eczema
- ☐ Sneezing/Hay Fever
- ☐ Frequent Infections

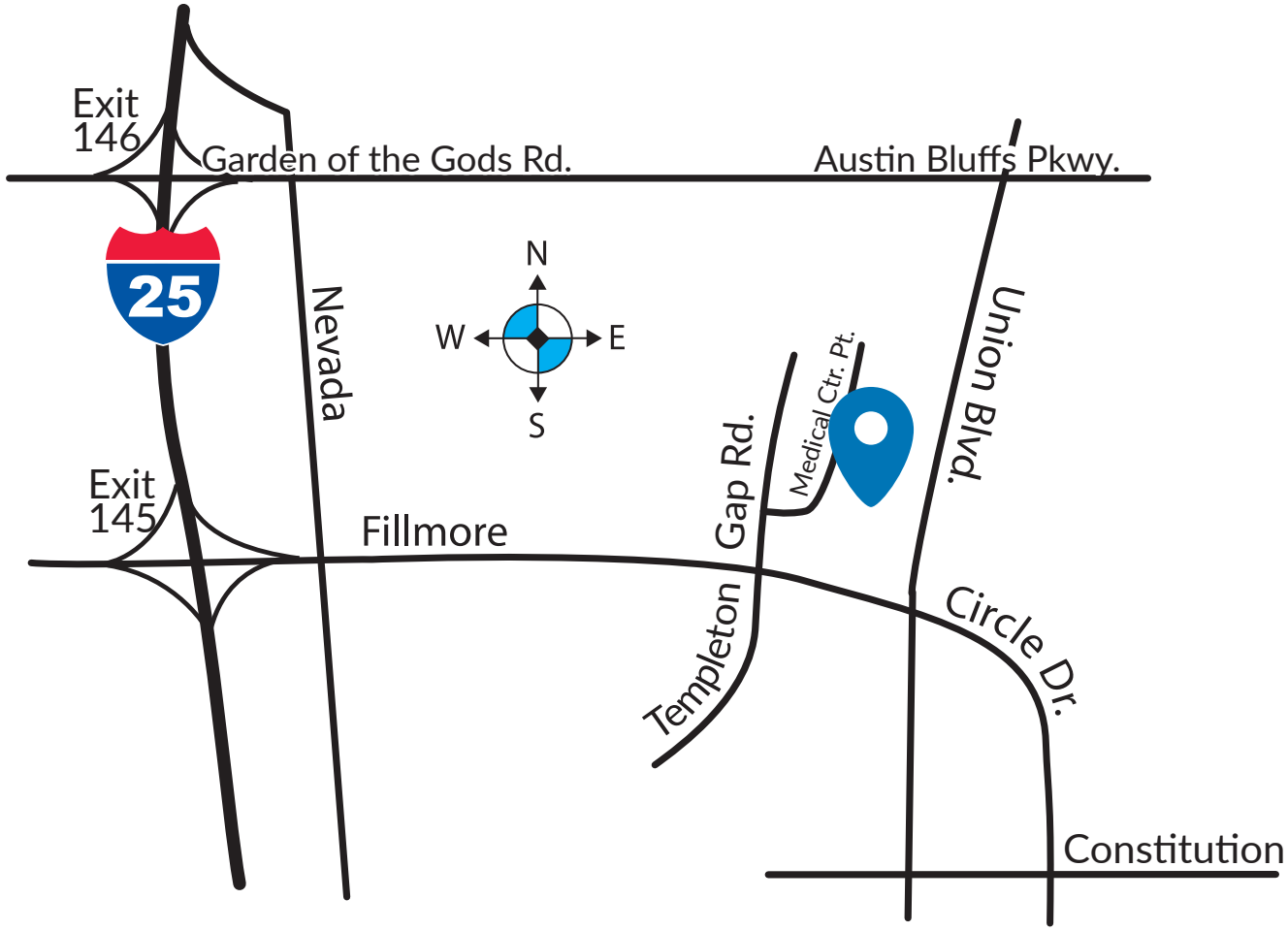
Skin
- ☐ Rash
- ☐ New Skin Lesions/Moles
- ☐ Itching/Burning

Endocrine
- ☐ Intolerance to Heat/ Cold
- ☐ Loss of Hair
- ☐ Night Sweats

Completed by: _____ **Date:** _____

Reviewed by physician: _____ **Date:** _____

DaVita Medical Group - Medical Center Point



*map not to scale

1625 Medical Center Point

Located on the northwest corner of Fillmore & Union

DaVita Medical Group