

Health Questionnaire

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



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	_____		

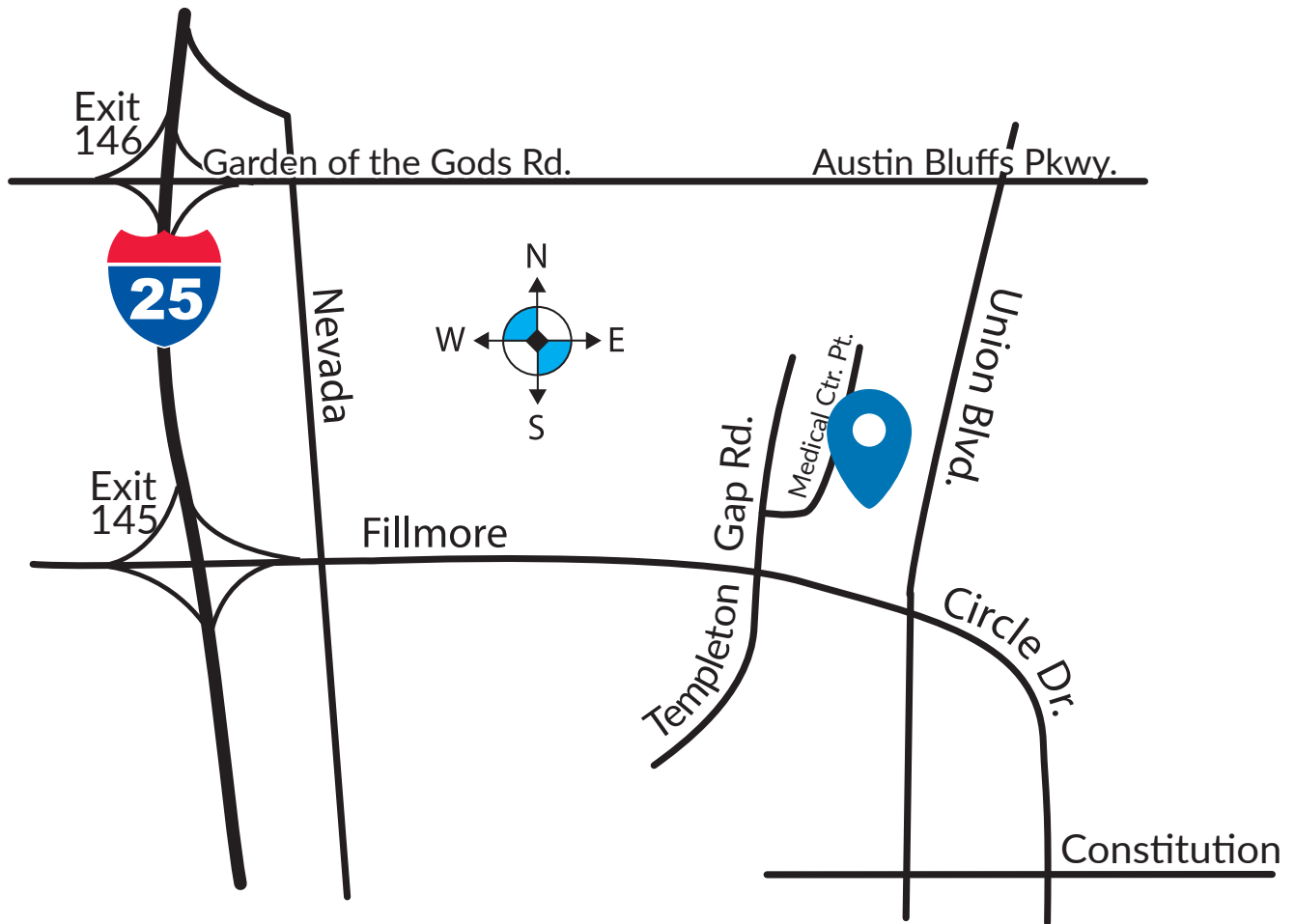
Review of Systems (please place a check mark next to any symptoms you CURRENTLY have):

<p>General</p> <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Weight Loss - Unexplained <input type="checkbox"/> Change in Sleep <input type="checkbox"/> Anemia <p>Ear, Nose, Throat</p> <input type="checkbox"/> Ringing In The Ears <input type="checkbox"/> Hearing Difficulties <input type="checkbox"/> Ear Pain <input type="checkbox"/> Runny Nose/ Cong./Obstruc <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Facial Pain/Pressure <input type="checkbox"/> Dental Pain/Mouth Sores <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal Obstruction	<p>Eye</p> <input type="checkbox"/> Eye Pain <input type="checkbox"/> Blurry/Double Vision <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Flashing Lights <p>Cardiovascular/ Heart</p> <input type="checkbox"/> Chest Pain/ Pressure <input type="checkbox"/> Palpitations <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Difficulty Laying Flat <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Blood Clots <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Disease	<p>Gastrointestinal</p> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Yellow Skin Or Eyes <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Black/Bloody Stool <input type="checkbox"/> Ulcers <input type="checkbox"/> Excessive Gas/Bloating <p>Respiratory/ Lung</p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apneas	<p>Mental Health</p> <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Mood Swings <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Difficulty Concentrating <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Stress; Severe <p>Neurological</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Loss of Strength <input type="checkbox"/> Migraines/Headaches <input type="checkbox"/> Memory Loss <input type="checkbox"/> Tremors <input type="checkbox"/> Seizure Activity <input type="checkbox"/> Headache- Severe	<p>Hematology/Lymphatic</p> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Gums Bleed Easily <input type="checkbox"/> Enlarged/Tender Lymph Nodes <p>Allergy/Immunologic</p> <input type="checkbox"/> Hives/Eczema <input type="checkbox"/> Sneezing/Hay Fever <input type="checkbox"/> Frequent Infections <p>Skin</p> <input type="checkbox"/> Rash <input type="checkbox"/> New Skin Lesions/Moles <input type="checkbox"/> Itching/Burning <p>Endocrine</p> <input type="checkbox"/> Intolerance to Heat/ Cold <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Night Sweats
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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

