Randolph Health Ear Nose & Throat
Adult Health History Questionnaire

Name _____ Sex F M Date _____

Pharmacy you use _____ Family doctor _____

Please circle anything you are currently experiencing or have a problem with:

Constitutional
Fevers
Night sweats
Unexplained weight loss

Skin
Skin dryness or rashes
Skin lesions that are changing

ENT
Hearing loss
Ringing in the ears
Do you use hearing aids
Difficulty breathing through nose
Nasal drainage
Nasal congestion
Nosebleeds
Toothache/loose teeth
Do you wear dentures
Sore throat
Hoarseness

Allergies
Food Allergies
Allergies to dust or pollen
Chemical sensitivities (perfume etc)

Respiratory
Cough
Wheezing
Shortness of breath

Cardiovascular
Chest pain
Irregular heartbeat/palpitations
Heart Murmur
Ankle swelling

Gastrointestinal
Difficulty swallowing
Heartburn or indigestion
Abdominal pain

Eye
changes in vision
light sensitivity
do you wear glasses or contacts
Double vision

Endocrine
excessive thirst
excessive urination
changes in hair or nails
do you have a goiter

Hematology
Lumps in neck, groin, armpits
abnormal bleeding or bruising

Urology
Difficulty with urination
inability to hold urine
blood in urine

Neurology
tremors/shakes
slurred speech
headaches
weakness in face
weakness in arms legs
dizziness

Psychology
Depression
Anxiety

Muscloskeletal
painful joints
joint swelling
Do you grit your teeth

Name_____

Are you allergic to any medications, if so please list them and your reaction;
_____
_____

Medications you are taking; list dosage and how taken; if you have your medicines with you or a list skip this question;
_____
_____
_____
_____
_____
_____
_____
_____
_____

Hospitalizations (other than operations) please list description and date;
_____
_____
_____

Marital Status: Single Married Divorced Separated Widowed Occupation:_____
Have you smoked cigarettes? Y N Packs Per day ____ How many years? _____ If you quit, when? _____
Do you Chew Tobacco or use snuff? Y N How much per week?_____ How many years? _____
Do you drink alcohol? Y N How much per week? _____ Illegal drug use? Y N

Have you had any of the following operations;			Date
Ear Tubes	YES	NO	_____
Adenoidectomy	YES	NO	_____
Tonsillectomy	YES	NO	_____
Nasal/sinus surgery	YES	NO	_____
Hernia repair	YES	NO	_____
Gallbladder	YES	NO	_____
Hemorrhoids	YES	NO	_____
Hysterectomy	YES	NO	_____
Cataract Surgery	YES	NO	_____
Breast Biopsy	YES	NO	_____
Others;_____			_____

_____
_____

Name_____ Adult History Medical Problems

Please circle any of these that you have a history of;

Hearing loss	High Blood Pressure	Skin Cancer
Allergies	Hepatitis	Kidney Stones
AIDS/HIV	Stomach Ulcers	Headaches
Asthma	Glaucoma	Stroke
Emphysema	Diabetes	Seizures/convulsions
TB (tuberculosis)	Thyroid Disease	Depression
Heart Disease	High cholesterol	Arthritis

Cancer (type) _____

Please circle any of the following your immediate family has a history of;

Hearing loss which family member(s)?_____

Allergies which family member(s)?_____

AIDS/HIV which family member(s)?_____

Asthma which family member(s)?_____

Emphysema which family member(s)?_____

TB (tuberculosis) which family member(s)?_____

Heart Disease which family member(s)?_____

Heart murmur which family member(s)?_____

High Cholesterol which family member(s)?_____

Skin Cancer which family member(s)?_____

Kidney stones which family member(s)?_____

Headaches which family member(s)?_____

Stroke which family member(s)?_____

Seizures/convulsions which family member(s)?_____

Depression which family member(s)?_____

Arthritis which family member(s)?_____