Ear, Nose & Throat
Surgical Associates, S.C.

Name _____

DOB _____

Established Patient Medical History Questionnaire

Any **NEW** concerns you would like to address today at your visit? _____

_____

Have you had any **NEW** diagnoses since your last visit? ☐ **YES** ☐ **NO**

Diagnosis _____ Date _____

Diagnosis _____ Date _____

Have you had any **NEW** surgeries since your last visit? ☐ **YES** ☐ **NO**

Surgery _____ Date _____

Surgery _____ Date _____

Have you started any **NEW** medications since your last visit? ☐ **YES** ☐ **NO**

Medication _____ Medication _____

Medication _____ Medication _____

Have you had any **NEW** allergies or adverse reactions to medication since your last visit? ☐ **YES** ☐ **NO**

If YES, please explain. _____

Are you **currently** having any of the following problems? **(Please check)**

Eyes
- ☐ Dry or itchy eyes
- ☐ Decreased vision

Ears
- ☐ Ringing or noise in the ears
- ☐ Ear pain or drainage
- ☐ Hearing loss

Nose
- ☐ Blocked or runny nose
- ☐ Loss of smell
- ☐ Nose bleeds

Throat
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Hoarse/rough voice
- ☐ Frequent throat-clearing

Heart
- ☐ Chest pain with activity
- ☐ Irregular heartbeat

Lungs
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma

Stomach
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea or vomiting
- ☐ Bloody stools

Bones and Muscle
- ☐ Arthritis
- ☐ Muscle pain

Skin
- ☐ Changes in mole or wart
- ☐ New skin growth

Neuro
- ☐ Change in facial muscle strength
- ☐ Loss of facial sensation
- ☐ Headaches

Allergy/Immuno
- ☐ Seasonal allergies

General
- ☐ Fever greater than 99 degrees
- ☐ Unexplained weight loss
- ☐ Fatigue/Weakness