Name: _____ Date: _____

Coastal Carolina Otolaryngology Associates, P.A.

Patient Medical History Questionnaire

Medical History: Please list all illnesses. (i.e., cancer, diabetes. high blood pressure, stroke, heart attack, etc.)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Surgical History: Please list all of the surgeries that you have had and the approximate date performed.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Family History: Please list all illnesses that run in your immediate family, including hearing loss.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Social History:

Do you smoke or use tobacco products? _____ If yes, what type, how much and for how long? _____

If not, have you ever used tobacco products? _____ How? _____

Do you drink alcoholic beverages? _____ How much in an average week? _____

How many caffeinated beverages do you consume daily? _____

Allergies: Please list all allergies (both to medications and environmental allergens) that you have.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Current Medications: Please list all current medications and their dosages if known or allow us to copy your list.
*** INCLUDE OVER THE COUNTER MEDICATIONS**

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Is there a possibility that you may be pregnant? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐ No HIV? ☐ Yes ☐ No

Review of Systems: Please answer the following questions regarding how you feel currently. Do you or have you recently had any of the following?

EYES		
Visual changes in the past year?	Yes	No
Glaucoma?	Yes	No
Double or blurred vision?	Yes	No
Pain, Redness or Dryness?	Yes	No
EARS		
Hearing Problems?	Yes	No
Ringing in the ears?	Yes	No
Discharge from the ears?	Yes	No
Loss of balance/vertigo?	Yes	No
Ear Pain?	Yes	No
Pressure in the ears?	Yes	No
Frequent ear infections?	Yes	No
History of loud noise exposure?	Yes	No
NOSE		
Nasal congestion?	Yes	No
Nasal discharge?	Yes	No
Post nasal drip?	Yes	No
Loss of smell?	Yes	No
Frequent nose bleeds?	Yes	No
Snoring?	Yes	No
Injury to the nose?	Yes	No
Nasal or sinus surgery?	Yes	No
Frequent sinus infections?	Yes	No
THROAT		
Sore throat?	Yes	No
Frequent throat infections?	Yes	No
Painful or difficulty swallowing?	Yes	No
Hoarseness?	Yes	No
HEART		
Heart problems?	Yes	No
High blood pressure?	Yes	No
Angina/chest pain?	Yes	No
Swelling in the ankles?	Yes	No

Please complete back side of form.

Name: _____ **Date:** _____

CHEST

Asthma?	Yes	No
Bronchitis?	Yes	No
Shortness of breath?	Yes	No
Wheezing?	Yes	No
Chronic cough?	Yes	No
Cough blood?	Yes	No
History of Tuberculosis?	Yes	No

DIGESTIVE

Stomach problems?	Yes	No
Heartburn/ulcers?	Yes	No
Gallstones?	Yes	No
Vomited blood?	Yes	No
Chronic constipation/diarrhea?	Yes	No
Blood in the stools?	Yes	No
Liver problems?	Yes	No

GENITOURINARY

Kidney stone?	Yes	No
Frequent urination?	Yes	No
Bladder infections?	Yes	No
Painful urination?	Yes	No

NEUROLOGICAL

Frequent severe headaches?	Yes	No
Weakness/paralysis?	Yes	No
Tremors?	Yes	No
Convulsions/seizure?	Yes	No
Stroke?	Yes	No
Loss of consciousness?	Yes	No

MUSCULOSKELETAL

Severe back pain?	Yes	No
Arthritis/bursitis?	Yes	No

ENDOCRINE

Diabetes?	Yes	No
Thyroid condition?	Yes	No

BLOOD

Anemia?	Yes	No
Easy bruising?	Yes	No
Received transfusions?	Yes	No

The above information is true and correct to the best of my knowledge?

Signed _____ Date _____