

**MEDICAL QUESTIONNAIRE**

**PATIENT:** \_\_\_\_\_

Instructions to patient: **PLEASE ANSWER ALL QUESTIONS** Please indicate by a check your answer to each question. These answers will greatly help your doctor to give you his (or her) best care. If yest do not understand any question or answer is uncertain simply place a question mark in the column.

Have you had or still have?:	NO	NOW	PAST	REMARKS	Have you had or still have?:	NO	NOW	PAST	REMARKS
Difficulty Hearing					Chest Pain,Angina				
Dizziness					Heart Attack (s)				
ringing in the Ear					Palpitations/irregular/fast heart beat				
Ear Pain					Anemia/Blood Disorders				
Facial Paralysis					Bleeding Disorders				
Headaches					Sickle Cell Illness				
					Infectious Mononucleosis				
Difficulgy breathing through nose					Jaundice, Hepatitis				
Loss of smell / taste					Liver Trouble				
Post Nasal Drip					Gallbladder Trouble				
Drainage from Nose					Back Pain or Injury				
Pressure behind the eyes					Ulcer Disease				
Facial Discomfort					Bleeding from Stomach				
Snoring					Stroke				
					Seizures				
Pain / Swelling with Meals					Thyroid Trouble				
Pain with Chewing					Diabetes				
Clicks / Popping in Jaw Joints					Low Blood Sugar				
Orthodontic Treatment-braces					Kidney Trouble				
Chronic Sore Throats					Joints Replaced with Prosthesis				
Difficulty Swallowing									
Lump in the Throat									
Persisting Hoarsness/ Voice Change					Are you running a fever?				
Lump in the Head/Neck Area					If female, are you pregnant?				
Facial Injuries					What operations have you had?				
Auto Accident Injury									
Whiplash Injury									
Bronchitis, a chronic cough									
Asthma									
Allergy Treatment or Shots					Have you had blood transfusion?				
Hay Fever					Any history of cancer or other disease in your family?				
Pneumonia					Have you or your family had an unusual reaction to anesthesia?				
Tuberculosis					either local or general?				
Emphysema					Are you taking medications (or recently took)?				
Shortness of Breath					blood pressure				
Any Other Lung Trouble					diuretic (water pills)				
					anti depresants				
Rheumatic Fever					tranquilizers				
Heart Disease					blood thinners				
Heart Murmur/Mitral Valve Prolapse					eye drops				
High Blood Pressure					pain pills, or shots				
Low Blood Pressure					steroids, cortisol, A.C.T.H.				
					diabetic medication				
A Sexually Transmitted Disease					sleeping tablets				
High Risk for AIDS or Hepatitis					Birth Control Pills				
AIDS or HIV					Other				

Do you **NOW**, or have you **EVER**, smoked cigarettes? \_\_\_ Yes \_\_\_ No If so, how much? \_\_\_\_\_

Quit, when? \_\_\_\_\_

Do you drink beer, or other alcoholic beverages? \_\_\_ Yes \_\_\_ No If so, how much? \_\_\_\_\_

Quit, when? \_\_\_\_\_

Signature of Person Filling Out Form \_\_\_\_\_

Date: \_\_\_\_\_