

# ARKANSAS OTOLARYNGOLOGY PATIENT QUESTIONNAIRE

Date \_\_\_\_\_ Name \_\_\_\_\_ Sex M F Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Consult Requested By \_\_\_\_\_ Family Doctor \_\_\_\_\_  
First Last First Last

**Chief Complaint:** (What is the main reason for your visit?) \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

**Review of Systems:** (Please answer Yes or No to each symptom)

Fever/Night Sweats/Weight Loss	Y	N	Swollen Joints	Y	N
Visual Disturbances	Y	N	Skin Rash/Itching	Y	N
Hearing Loss	Y	N	Balance Problems/Tremors/Dizziness	Y	N
Ringing in the Ears	Y	N	Confusion/Depression	Y	N
Chest Pain	Y	N	Dry Skin	Y	N
Shortness of Breath	Y	N	Bleed or Bruise Easily	Y	N
Throat Problems	Y	N	Allergic/Immune Problems	Y	N
Nasal Problems	Y	N	Heartburn/Nausea/Vomiting/Abdominal Pain	Y	N
Urinary Problems	Y	N			

**Past Medical History:** (Please circle all that apply to you)

Diabetes	Asthma	Ulcers
High Blood Pressure	Pneumonia	Reflux
Heart Attack	Tuberculosis	Hiatal Hernia
Heart Rhythm Problems	Emphysema	Liver Disease
Mitral Valve Prolapse	Anemia	Hepatitis
Rheumatic Fever	Seizures	Thyroid Disorder
Bleeding Problem	Arthritis	Cancer
Stroke	Glaucoma	HIV Exposure/AIDS
Noise Exposure	Kidney Problems	Radiation/Chemotherapy

Have you ever been allergy tested?                      Y              N  
 When? \_\_\_\_\_  
 List what was Positive \_\_\_\_\_

Female Patients: Are you Pregnant?                      Y              N  
 Using Birth Control?                      Y              N

Please list any other serious medical problems. \_\_\_\_\_

**Past Surgical History**

Have you ever had surgery of any kind before?                      Y              N

Have you had previous problems with anesthesia?                      Y              N      Please Describe:

Bleeding Problem:  
 Do you bruise easily or bleed excessively when cut?                      Y              N

Please list any surgery you have had: \_\_\_\_\_

**Allergies**

Do you have any drug allergies?                      Y              N                      If yes, please list \_\_\_\_\_  
 Latex Allergy?                      Y              N                      \_\_\_\_\_

Please list all current medications, including prescriptions and "over the counter" medications.

	MEDICATION	DOSE	FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Are you taking any natural/alternative medications or products? Y N

St. John's Wort	Y	N	Other _____
Ginko Biloba	Y	N	_____
Ginseng	Y	N	_____

**Social History**

Do you use **tobacco**? Y N How much per day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use **alcohol**? Y N How often? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use any recreational drugs? Y N List \_\_\_\_\_

What is your occupation? (If retired, please list former occupation) \_\_\_\_\_

**Family History**

Are you married? Y N

Do you have a family history:	Hearing Loss	Y	N
	Malignant Hyperthermia	Y	N
	(High temperature after surgery)		
	Muscle Disease	Y	N
	Cancer	Y	N
	Diabetes	Y	N
	Heart Disease	Y	N
	Complications with anesthesia	Y	N
	Bleeding disorders	Y	N

**Pediatric History** (For children only)

Birth Weight \_\_\_\_\_ lbs.

Please Explain

C-Section?	Y	N
Premature?	Y	N
Problems with Pregnancy?	Y	N
Problems at birth?	Y	N
Apnea?	Y	N
Monitored?	Y	N

Reviewed by Physician \_\_\_\_\_

**CURRENT UPDATE MUST BE WITHIN 30 DAYS PRIOR TO SURGERY DATE.**

Reviewed and Updated \_\_\_\_\_

Date

Signature