PHYSICIANS' CLINIC
of Iowa, P.C.

EAR, NOSE & THROAT QUESTIONNAIRE

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No

Family Physician _____ Referring Physician _____

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____

REVIEW OF SYSTEMS: *Please check all symptoms you have experienced:*

Ear, Nose & Throat

☐ Yes ☐ No Change in Smell
☐ Yes ☐ No Change in Voice
☐ Yes ☐ No Ear Infections
☐ Yes ☐ No Ear, Throat, Facial Pain (Rate pain on a scale of 0-10 _____)
☐ Yes ☐ No Headaches
☐ Yes ☐ No Neck Mass
☐ Yes ☐ No Neck Pain (Rate pain on a scale of 0-10 _____)
☐ Yes ☐ No Nose Bleeds
☐ Yes ☐ No Problems Swallowing
☐ Yes ☐ No Ringing in Your Ears
☐ Yes ☐ No Nasal Congestion or Sinus Issues
☐ Yes ☐ No Snoring
☐ Yes ☐ No Thyroid Problems
  ☐ Yes ☐ No Do you have a family history of thyroid cancer/disease?
  ☐ Yes ☐ No Do you have a history of radiation exposure?
☐ Yes ☐ No Loss of Hearing
  ☐ Yes ☐ No Have you ever used a hearing aid?
  ☐ Yes ☐ No Do any of your family members use hearing aids?
  ☐ Yes ☐ No Do you have any loud noise exposure?
  ☐ Yes ☐ No Does hearing fluctuate?
  ☐ Yes ☐ No Sudden hearing loss?
  ☐ Yes ☐ No Do you have a family history of hearing loss?
☐ Yes ☐ No Dizziness/Vertigo
  When did you first notice it? _____
  ☐ Yes ☐ No Light Headed
  ☐ Yes ☐ No Loss of Consciousness
  ☐ Yes ☐ No Loss of balance when walking
  ☐ Yes ☐ No Objects spinning or turning around you
☐ Other _____

Constitutional/General

☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Unexplained Weight Loss/Gain

Eyes

☐ Yes ☐ No Change in Vision
☐ Yes ☐ No Itchy/Watery Eyes

Respiratory

☐ Yes ☐ No Cough
☐ Yes ☐ No Shortness of Breath

Cardiovascular

☐ Yes ☐ No Chest Pain or Discomfort
☐ Yes ☐ No Irregular Heart Beat/Palpitations

Gastrointestinal

☐ Yes ☐ No Indigestion or Heartburn
☐ Yes ☐ No Swallowing Difficulties

Psychological

☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety

Genitourinary

☐ Yes ☐ No Loss of Urinary Control

Skin

☐ Yes ☐ No Skin Rash/Itching

Musculoskeletal

☐ Yes ☐ No Limitation of Motion (Neck)

Hematologic/Lymphatic

☐ Yes ☐ No Swollen Glands

Other _____

PAST SURGERY: *Have you had any of the following surgeries? (Check all that apply.)*

☐ Yes ☐ No Ear Surgery
☐ Yes ☐ No Nasal/Sinus Surgery
☐ Yes ☐ No Neck Surgery
☐ Yes ☐ No Throat Surgery
☐ Yes ☐ No Other Ear, Nose or Throat Surgery:
_____
_____

SOCIAL HISTORY: *(0-12 years ONLY)*

Child's grade level _____

☐ Yes ☐ No Does your child go to day care?
☐ Yes ☐ No Is your child exposed to second hand smoke?

CONTINUED ON OTHER SIDE

MEDICAL HISTORY:

☐ Yes ☐ No Bleeding/Clotting Problems
☐ Yes ☐ No Cancer (Type: _____)
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Head Injury
☐ Yes ☐ No HIV
☐ Yes ☐ No MRSA
☐ Yes ☐ No Problems with Anesthesia
☐ Other _____

Do you have sensitivity to Latex? ☐ Yes ☐ No

FAMILY HISTORY: Has any ***member of your family*** ever had the following? If yes, indicate family member. ***Do not include spouse or in-laws.***

		Which Family Member?
☐ Yes ☐ No	Allergies	_____
☐ Yes ☐ No	Cancer (include type)	_____
☐ Yes ☐ No	Problems with Anesthesia	_____
☐ Yes ☐ No	Problems with Bleeding/Clotting	_____

Patient/Parent Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____