HEAD & NECK SURGICAL GROUP
PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ HEIGHT:_____ WEIGHT: _____

REVIEW OF SYSTEMS - CHECK ALL THAT APPLY:

Head & Neck
- ___ Eye Disease
- ___ Double vision
- ___ Blurred vision
- ___ Prior Ear Surgery
- ___ Ear Ache
- ___ Hearing loss
- ___ Dizziness
- ___ Ringing in ears
- ___ Nasal Obstruction
- ___ Nosebleeds
- ___ Nasal Discharge
- ___ Altered sense of smell
- ___ Sinusitis
- ___ Nasal Polyps
- ___ Snoring
- ___ Excessive sleepiness
- ___ Facial pain
- ___ Pain with chewing
- ___ Recent dental work
- ___ Mouth sores
- ___ Lumps in the neck
- ___ Allergies

Respiratory System
- ___ Hoarseness
- ___ Chronic cough
- ___ Throat clearing
- ___ Heart Burn
- ___ Regurgitation
- ___ Spitting up blood
- ___ Shortness of breath
- ___ Wheezing
- ___ Asthma
- ___ Chronic bronchitis
- ___ Chest Pain
- ___ Emphysema
- ___ Tuberculosis
- ___ Lung cancer

Neurologic
- ___ Headaches
- ___ Head injury
- ___ Numbness or tingling
- ___ Transient black-outs
- ___ Transient vision loss
- ___ Seizures
- ___ Strokes

General
- ___ Night Sweats
- ___ Fevers
- ___ Skin diseases
- ___ Arthritis
- ___ Bleeding Disorder
- ___ Easy Bruisability
- ___ HIV infection or AIDS
- ___ Psychiatric Diseases

Gastrointestinal
- ___ Difficult swallowing
- ___ Pain on swallowing
- ___ Diarrhea
- ___ Constipation
- ___ Jaundice
- ___ Liver Disease
- ___ Hepatitis
- ___ Kidney Disease
- ___ Bloody stools
- ___ Diverticulosis
- ___ Gall bladder disease
- ___ Heartburn or ulcers

Cardiovascular
- ___ Hypertension
- ___ Heart disease
- ___ Angina
- ___ Swelling of the ankles
- ___ Heart surgery
- ___ Angioplasty
- ___ Pacemaker
- ___ Anemia

Endocrine
- ___ Diabetes
- ___ Heat/cold intolerance
- ___ Thyroid imbalance
- ___ Menstrual disorders

Urologic
- ___ Difficulty on urination
- ___ Frequent urination
- ___ Blood in the urine
- ___ Prostate problems

Other
_____

Past and present medical problems:	***Previous surgeries and dates (month/year)***	***List all current medications and dosages (including OTC):***
_____	_____ (/)	_____
_____	_____ (/)	_____
_____	_____ (/)	_____
_____	_____ (/)	_____
_____	_____ (/)	_____
_____	_____ (/)	_____

Do you smoke?
___ Yes ___ No
If yes, how much?
_____

Do you drink alcohol?
___ Yes ___ No
If yes, how much?
_____

Any other information for Dr.?
_____
_____
_____

Please list <u>all</u> allergies:
(medications, inhalants, foods, contact allergies) _____

Reason for today's visit: _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____