



# 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?

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