

**Health History Questionnaire- New Patient -  
Otolaryngology**

NAME:

MRN:

BIRTHDATE:

AGE:

**Please fill this form out as completely as possible and bring this to your appointment.**

Date of Appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

If you are an existing patient to the University of Michigan Hospital and Health Centers, you may skip the medication list and allergies/adverse reactions sections below. You will be given a printed list of medications and allergies which you will edit when you arrive at the clinic.

What is the reason for your visit (chief complaint)? \_\_\_\_\_

What is your most recent occupation (if age 18 years or older)? \_\_\_\_\_

**Medication List**

Please list the names of any medications that you are currently taking below. Please indicate the correct dosage and frequency (if known). Include supplements, herbals and over the counter medications. If you are unsure, ask your clinician.

<u>Medication Name</u>	<u>Dose / Frequency (How often taken)</u>	<u>Refills Needed?</u> If yes, circle the days supply
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90
_____	/	30 / 90

Please indicate any non-medication prescriptions for which you need refills (such as supplies):

**Allergies / Adverse Reactions**

Please indicate any medications, foods, etc. to which you have had an allergic or bad reaction.

What are you allergic to?

What happened when you took or used it?

**Past Medical History** (Check any medical problems you have had):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> COPD                               | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Arrhythmia(Palpitations) | <input type="checkbox"/> Deep vein thrombosis               | <input type="checkbox"/> MI (Heart attack)  |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Depression                         | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Bleeding disorder        | <input type="checkbox"/> Diabetes mellitus                  | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Emphysema                          | <input type="checkbox"/> Skin cancer        |
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Hearing loss                       | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Chronic lung disease     | <input type="checkbox"/> Hepatitis                          | <input type="checkbox"/> Substance abuse    |
| <input type="checkbox"/> Cirrhosis                | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Syncope (Fainting) |
| <input type="checkbox"/> Clotting disorder        | <input type="checkbox"/> Kidney disease                     | <input type="checkbox"/> Thyroid disease    |
| <input type="checkbox"/> Congestive heart failure |   |   |

Other (specify): \_\_\_\_\_

**FOR OFFICE STAFF: COLLECTED INFORMATION MUST BE ENTERED IN MICHART. PLEASE DO NOT SEND THIS FORM TO HEALTH INFORMATION MANAGEMENT FOR FILING.**

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**Past Surgical History** (Check any surgeries you have had and state date of surgery if you know it):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Adenoidectomy                          | <input type="checkbox"/> Facial fracture surgery | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Brain surgery                          | <input type="checkbox"/> Heart surgery           | <input type="checkbox"/> Sinus surgery     |
| <input type="checkbox"/> CABG (Heart bypass)                    | <input type="checkbox"/> Hernia repair           | <input type="checkbox"/> Tonsillectomy     |
| <input type="checkbox"/> Cholecystectomy (Gall bladder removal) | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Facial cosmetic surgery                | <input type="checkbox"/> Joint replacement       |  |

Other (specify): \_\_\_\_\_

**Family History**

Check below to report problems your family members have had. Please state age when they had problem, if you know it.

I was adopted. So, I don't know my family history.

	<u>Mother</u>	<u>Father</u>	<u>Sister</u>	<u>Brother</u>	<u>Daughter</u>	<u>Son</u>	<u>Other (list)</u>
Anesthesia problems							
Bleeding disorder							
Clotting disorder							
Hearing loss							
Heart disease (<45 years old)							
Cancer (what type?)							
Other (specify):							
Alive? (Yes, No or N/A=Not applicable)							

**Social History**

Do you ever drink alcohol?  Yes  No

If yes, please indicate the quantity per week of each:

- Glasses of wine \_\_\_\_\_
- Cans/bottles of beer \_\_\_\_\_
- Shots of liquor \_\_\_\_\_
- Drinks containing 0.5 oz of alcohol \_\_\_\_\_

Check one of the following about smoking tobacco:

- Never smoked
- Former smoker
- Smoke some days
- Smoke every day
- Exposed to second hand smoke

If you do smoke or used to smoke, how many packs do/did you smoke per day? \_\_\_\_\_

How many years did you smoke/have you smoked? \_\_\_\_\_

If you quit, when did you quit? \_\_\_\_\_

Do you use "smokeless tobacco?" (select one below)

- Former user
- Current user
- Never used

If you quit, when did you quit? \_\_\_\_\_

Are you ready to quit smoking and/or using smokeless tobacco?  Yes  No

Do you use drugs?  Yes  No

If you use drugs, how many times per week: \_\_\_\_\_

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