

**BETHLEHEM ENT ASSOCIATES
HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CORRECT WAY TO MARK CIRCLES: ●

Patient's Name: _____
Referred by: _____
Family doctor: _____

Today's Date: _____
Date of Birth: _____
Age: _____
Sex: _____

How did you hear about our office? Emergency Room Friend Phone Book Newspaper
 Relative Doctor Other: _____

1. What is the reason for today's visit?

2. What medications do you take?

None Aspirin Ibuprofen (Advil, Motrin) Tylenol Birth Control

Additional medications list below, include over the counter medications.

<u>Name of Drug</u>	<u>Strength</u>	<u>Frequency Taken</u>

3. Do you have any Allergies or Reactions? No Yes If yes, please list below:

<u>Allergy</u>	<u>Type of reaction</u>

4. Have you had any surgeries? No Yes If yes, please list below:

<u>Year</u>	<u>Reason</u>	<u>Hospital</u>

Patient's Name: _____

5. Are you currently employed? No Yes If yes, what is your occupation:
If not employed, are you Student Retired Disabled

6. What is your marital status? N/A Single Married Divorced Separated Widowed

7. How many children do you have? N/A 1 2 3 4 5 6 7 8 >8

8. Have you ever smoked? No Yes

If yes, how many packs per day? Less than one One Two Three or more

If yes, how many years? 1-5 6-10 11-20 More than 20

Did you quit smoking? No Yes If yes, when did you quit:

9. Do you drink alcohol? No Yes If yes, how frequent? Rarely Socially (2 to 3 per week) Daily

10. Please mark all major medical problems that apply for your immediate family.

No Significant Family History Unknown

Stroke Heart Disease Diabetes Cancer Bleeding Disorder

Arthritis High blood pressure Other - list below

11. Indicate **all** medical conditions you've had in the past. No Significant History

- | | | | |
|---|---|--|---|
| <input type="radio"/> Asthma | <input type="radio"/> Arthritis | <input type="radio"/> Cancer | <input type="radio"/> Diabetes |
| <input type="radio"/> Environmental allergies | <input type="radio"/> Heart attack | <input type="radio"/> Heart murmur/condition | <input type="radio"/> Hepatitis |
| <input type="radio"/> High blood pressure | <input type="radio"/> HIV/AIDS | <input type="radio"/> Lung disease | <input type="radio"/> Psychiatric treatment |
| <input type="radio"/> Reflux | <input type="radio"/> Stomach problems/ulcers | <input type="radio"/> Stroke | <input type="radio"/> Thyroid disorder |
| <input type="radio"/> Other - list below: | | | |

12. Check the problems you have had in the last 6 months. **Choose all that apply.**

Eyes: No Problems Itchy Excessive tearing Vision change
 Glasses Contacts

Ears: No Problems Hearing loss Discharge Imbalance
 Hearing Aid Infections

Nose: No Problems Obstruction Discharge/runny Bleeding
 Foul odor Loss of smell

Mouth: No Problems Sores/ulcers Altered taste Dental problems

Throat: No Problems Pain Difficulty swallowing Hoarseness

