City ENT PLLC

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PATIENT QUESTIONNAIRE

Patient Name: ______________________________

Planned Procedure: ______________________________

____

____

Please list ALL PAST SURGERIES:

____

____

____

Anesthesia Problems: ☐ **Yes** ☐ **No**

If Yes, please list:

____

Please list ALL MEDICATIONS, including DOSAGE:

____

____

____

____

____

List any ALLERGIES (medications/food/inhalant):

____

____

Do you smoke? ☐ Yes ☐ No

Did you previously smoke? ☐ Yes ☐ No

Packs per day: _______ for _______ years Quit _______

Do you use recreational drugs? ☐ Yes ☐ No

Please list ____________________ How often ________

____

Please list any non-prescription medications:
(e.g. cold tablets, vitamins)

____

Please list any HERBAL:
(e.g. Ginkgo, Ginseng, St. John's Wort, Echinacea)

____

____

Weight: ______________________________

Height: ______________________________

Check any symptoms you have recently experienced:

- ☐ Weight Loss
- ☐ Fatigue
- ☐ Other ____________________
- ☐ Fever / Chills
- ☐ Weakness
- ☐ Pain (identify location):

Please list ALL YOUR medical conditions:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ COPD
- ☐ Depression
- ☐ Excessive Bruising
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heat / Cold Problems
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Cancer: ________________
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Palpitations/Irregular heart
- ☐ Pneumonia
- ☐ Reflux
- ☐ Seizure
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Urinary Problems
- ☐ ADD/ADHD
- ☐ H/O Radiation
- ☐ Metal Implants or Pacemaker

Family History of Medical Conditions:

- ☐ Heart
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Stroke
- ☐ Cancer
- ☐ Other: ____________________
- ☐ Diabetes
- ☐ Emphysema

Are you interested in a cosmetic consultation?

☐ Yes ☐ No

Date: ______________________ **Signature**: ______________________________