

C H I C A G O
N A S A L & S I N U S
C E N T E R

Medical History Questionnaire

PATIENT NAME _____

DATE _____

Please check any medical problem that you have been treated for or are currently being treated for:

- | | | | |
|------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Immune Disorder |

Current height: _____ Current weight: _____

Please list any other major illnesses or injuries: _____

Prior surgeries: _____

Current medications: _____

Medication allergies or adverse reactions: _____

Social History

Do you use chew or smoke tobacco? Yes No

If yes, how much, how often and for how long? _____

Do you drink alcoholic beverages? Yes No

If yes, how much and how often? _____

Review of Systems

Are you currently experiencing or have you experienced problems with:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Recurrent fevers | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ringing in the ears (tinnitus) | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis/Pneumonia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Aspiration |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Prostate problems (males) |
| <input type="checkbox"/> Pelvic pain (females) | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Limb or back pain | <input type="checkbox"/> Eczema or Psoriasis |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen lymph nodes |

Environmental/food allergies to (e.g. dust, mold, pollens, dander, etc.): _____