**FOR OFFICE USE ONLY**
Date _____
Ref Phy _____
Nurse Initial's _____
Dr. Initial's _____
PF_____

**Lawrence Otolaryngology Associates, LLC.** **Patient Chart #_____**
**Patient History Questionnaire**
**Answering ALL of the following questions will assist with your evaluation.**

Patient Name: _____ Date of Birth: _____Today's Date: _____

**Drug Allergies: YES / NO**
If YES please list below:

| **Allergy** | **Reaction** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**I have had Surgeries/Operations/Serious Illness: YES / NO**
If YES list <u>all lifetime</u> surgeries/operations below:

| **Year** | **Surgery/Operation/ Serious Illness** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Have you ever Smoked/Chewed Tobacco? (Circle one) YES / NO**

How Much? _____ Packs per day since_____ (yr.) Date quit: _____

**Do you use Alcohol? (Circle one) YES / NO** How Much? _____drinks per Day/Week/Month

**Family History**

| | **Father** | **Mother** | **Sibling** | **Grandparent** |
|---|---|---|---|---|
| **Cancer (list type)** | Y / N | Y / N | Y / N | Y / N M P |
| **Cholesterol** | Y / N | Y / N | Y / N | Y / N M P |
| **COPD/Emphysema** | Y / N | Y / N | Y / N | Y / N M P |
| **Diabetes** | Y / N | Y / N | Y / N | Y / N M P |
| **Hypertension** | Y / N | Y / N | Y / N | Y / N M P |
| **MI/Heart Disease** | Y/ N | Y / N | Y / N | Y / N M P |
| **Stroke** | Y/ N | Y / N | Y / N | Y / N M P |
| **Thyroid Disease** | Y/ N | Y / N | Y / N | Y / N M P |

**Do you have an Advance Directive? (Circle one) YES / NO**

☐ DPOA - Copy on file ☐ Living Will - Copy on file ☐ DNR - Copy on file
DPOA Name:_____

**Review of Current Personal Systems (check yes or no)**

| **<u>Constitutional</u>** | Yes | No | **<u>Gastrointestinal</u>** | Yes | No | **<u>Psychiatric</u>** | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Recent Weight Change | | | Heartburn | | | Psychiatric Illness | | |
| Regular Exercise | | | Intestinal Disorders | | | Feeling lonely/depressed | | |
| **<u>Eyes</u>** | | | Difficulty Swallowing | | | Hard to Concentrate | | |
| Decreased Vision | | | Hepatitis or Jaundice | | | Work or Family Problems | | |
| Double Vision | | | **<u>Genitourinary</u>** | | | **<u>Endocrine</u>** | | |
| Glaucoma | | | Kidney Trouble | | | Diabetes | | |
| **<u>Neoplastic</u>** | | | Difficulty Urinating | | | Feel too hot/cold | | |
| Cancer | | | Frequent Urination | | | Thyroid Problems | | |
| **<u>Cardiovascular</u>** | | | **<u>Neurological</u>** | | | **<u>Hematologic/lymphatic</u>** | | |
| Chest Pain | | | Muscle Weakness | | | Bleeding Tendency | | |
| High Blood Pressure | | | Numbness of Fingers or Toes | | | Exposure to AIDS Virus | | |
| Heart Murmur | | | Concussions | | | **<u>ENT</u>** | | |
| Valve Problem | | | Un-coordination | | | Hearing loss | | |
| **<u>Respiratory</u>** | | | Seizure Disorder | | | Frequent Colds | | |
| Asthma | | | Strokes | | | Hoarseness | | |
| Shortness of Breath | | | **<u>Skin</u>** | | | Hay fever | | |
| Coughing up Blood | | | Skin Disorders / Rashes | | | | | |
| Wheezing | | | | | | | | |

************CONTINUE ON BACK OF THIS PAGE************

**I am currently taking Prescription Medications, OTC Medications or Vitamins: Yes / No**

**If YES list ALL Medications (including over the counter medications and vitamins) doses and frequency**:
**If you have a list prepared please give it to the receptionist to copy.**

| Medication Name | Strength | Dosage | Medication Name | Strength | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Preferred Pharmacy:** _____
**Pharmacy Name** **Address** **Phone No.**

Mail Order Pharmacy: _____
Pharmacy Name Mailing Address

_____
Phone Number Fax Number

**BACKGROUND INFORMATION**
**(Please be as specific as possible)**

**Chief Complaint (why are you here?)** _____

**Location/site of the problem** _____

**Quality of the problem (e.g. Sharp or dull pain)** _____

**Severity of problem (e.g. mild, moderate, severe)** _____

**Timing/duration of problem (e.g. at night for 1 week)** _____

**Improving, worsening or staying the same?** _____

**Modifying factors (things that make it better or worse).**_____

**Associated signs or symptoms:** _____

**Please List All of your <u>Current</u> Physicians:**

| Physician Name | Specialty | City/State | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |