THE CENTERS FOR ADVANCED
ENT CARE
CHESAPEAKE EAR, NOSE, AND THROAT

Adult Patient Questionnaire

Date _____

Patient information					
Last Name, First Name			Current Address		Zip Code
Date of Birth	Age	Sex: Male Female	City, State	Occupation	
Marital status:	Race:		Height	Weight	
Primary care physician:			Country of Birth	How did you hear about us?	
Referring physician:					

Contact info: Please CIRCLE the preferred contact phone number What is preferred contact method?			
Home	Work	Cell	Email

Preferred Pharmacy Name and Address. Please provide phone number if possible

What is the nature of the problem that brought you into the office today?

Social History		
Do you smoke? Yes / No Other tobacco products?_____ If yes: How many packs daily? _____ How long (years)?_____		Did you smoke in the past? Yes / No When did you quit? _____ How many packs per day? _____
Do you drink alcohol? Yes / No How many drinks per week? _____	Do you use other recreational drugs? Yes / No Please specify _____	Do you exercise regularly? Yes / No How many times per week? _____

Medication Allergies: Please list your medicine allergies and the reaction.
None ☐

Are you pregnant or nursing? Yes ☐ No ☐

Past Medical History: Please CIRCLE any of the following you have/had in the past or present. Please add others not in the list		NONE
Cardiac (heart) disease	Thyroid disease	Bleeding/Clotting disorder
Hypertension (High blood pressure)	Psychiatric disorder _____	Headache
Diabetes	Asthma	Seizure disorder
High Cholesterol	Emphysema	Chronic Bronchitis
Cancer _____	Irritable Bowel Syndrome	Sleep apnea CPAP? Yes / No
Chronic ear disease	Gastroesophageal reflux (Acid reflux)	Hearing loss
Chronic sinusitis	Psoriasis/Eczema	Seasonal allergies
Other	HIV	Hepatitis

OVER→

CHESAPEAKE EAR NOSE & THROAT: A Division of CADENT LLC

Adult Patient Questionnaire

Past Surgical History: Please list all your surgeries and dates		NONE	
	Date		Date

Medications: Please list your current medications with dosages and frequency		NONE

Do you take any blood thinners? No ☐ Yes ☐ _____	Do you take vitamins/supplements? No ☐ Yes ☐ (Please list above)

Family History: CIRCLE conditions which run in the family		NONE
Cardiac (heart) Disease	Asthma or Seasonal Allergies	Bleeding or Clotting Disorder
Diabetes	Cystic Fibrosis	Neurologic disorder
Cancer _____	Hearing Loss	Anesthesia complications
Other:		

Review of Systems: Please CIRCLE all symptoms that you have experienced (in the last 3 months)	NONE
Constitutional	unexpected weight loss weight gain fever chills fatigue
Eyes	corrective lenses blurry vision double vision eye pain redness watering
ENT	headache difficulty swallowing nose bleeds ringing in ears earaches hearing loss
Cardiovascular	chest pain palpitations fainting murmurs
Respiratory	shortness of breath wheezing cough chest tightness pain with breathing snoring
Gastrointestinal	heartburn nausea vomiting constipation diarrhea bloody/tarry stools
Genitourinary	urinary frequency urinary urgency difficult or painful urination flank pain bleeding with urination
Musculoskeletal	joint pain swelling stiffness
Skin	skin changes sore that won't heal rash itching redness hives
Hematologic	easy bleeding bruising
Neurological	numbness tingling dizziness unsteady gait
Psychiatric	anxiety depression
Endocrine	excessive thirst heat intolerance cold intolerance
Allergic	reaction to foods or environment
Other (please list): _____	

OFFICE USE: Reviewed by							
	Date		Date		Date		Date
	Date		Date		Date		Date