MONTGOMERY OTOLARYNGOLOGY CONSULTANTS, PA

HEALTH QUESTIONAIRRE

NAME		**DATE**
AGE	**DRUG ALLERGIES**	
REASON FOR VISIT:		
CURRENT SYMPTOMS: *please list*		

SURGERY HISTORY: *with dates*	**HOSPITAL ADMISSIONS:** *with dates*	**MEDICAL HISTORY: please list all**
1. _____	1. _____	1. _____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____
5._____	5._____	5._____
6._____	6._____	6._____
	Pregnant: Yes/ No? _____	**Nursing: Yes/No?_____**

SOCIAL HISTORY

Cigarettes: Smoker/Non-Smoker: ____pk/day: for _____ years

Pipe / cigar / smokeless tobacco/ none

Alcohol _____ drinks per week

Coffee / caffeine _____ cups per day

Other drug use: please list

MEDICATIONS: *please list all current medications*

FAMILY HISTORY: **Please enter the medical history for the members shown below and indicate the diagnosis year for each condition**

Mother	**Father**	**Children:**
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____

Paternal Grand Father/Mother	**Maternal Grandfather/Mother**	**Siblings**
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____