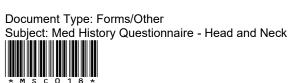
FIN:_____MRN:____

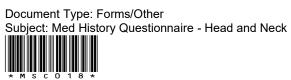




Room #____

HEAD AND NECK MEDICAL	L HISTORY QUESTIONNAIRE				
What are you being seen for:	How long have you had this?				
Referring Physician (First and last name):					
Primary Care Physician (First and last name):					
Dentist (First and last name):					
MEDICAL PROBLEMS (ex: high blood pressure, diabetes, etc.)	PREVIOUS SURGERIES / YEAR				
	/				
	/				
	/				
What year(s) were you diagnosed?	☐ Leukemia/lymphoma ☐ Other cancers:				
Treating physicians first and last names:					
MEDICATIONS	ALLERGIES				
PLEASE LIST <u>ALL</u> CURRENT MEDICATIONS <u>Including:</u> prescription, over the counter, birth control, vitamins, etc.	PLEASE LIST ALL MEDICATION / FOOD ALLERGIES DO YOU HAVE A LATEX ALLERGY? Yes No				
MEDICATION NAME DOSE / FREQUENCY	MEDICATION / FOOD ALLERGY REACTION				
Please compl	ete back of form				
Patient Label	PERMANENT PART OF MEDICAL RECORD				

FIN:_____MRN:____





SOCIAL HISTORY: This in	formation i	s kept str	ctly confidential. Howeve	r, you may	discuss t	his portion with the doctor if you լ	orefer.	
Employment status: ☐ Fu What type of work do you d						at home		
						cigarettes □ cigars □ vape □ years?] chew	
Do you drink alcohol curren Have you ever had a drinkir	tly? □ Ye ng problem	s □ No n? □ Yes	How many drinks per ☐ No When did you	week <i>(1 drir</i> ı quit (if no l	nk = 12oz onger us	z beer, 5oz wine, 1.5oz liquor)?_ ing)?		_
Recreational drugs: Cu	ırrent 🗆	Never [⊐ Former (Year You Quit) Тур	oe of drug	gs?		
	activities	(bathing,	eating, walking, getting di	ressed, etc.)	have an ? □ N	jections to blood transfusions? advanced directive/living will? o □ Sometimes □ Often chair □ Unable to walk at all	□ Yes □ Yes	□ No □ No
Living conditions: ☐ Ho						☐ Homeless ☐ Facility acility phone#:		
Are you pregnant?	□ Yes □	l No	Are you nursing?	□ Yes	□ No			
REVIEW OF SYSTEMS:	Have y	ou had a	ny of these problems in	the last sev	eral we	eks?		
Constitutional/Whole Body	,		Heart and Lung			Neurologic/Psychiatric		
Night sweats	☐ Yes	□ No	Chest Pain / angina	☐ Yes	□ No	Frequent Headaches	☐ Yes	□ No
Recurrent fevers	☐ Yes	□ No	Vascular / artery disease	☐ Yes	□ No	Anxiety	☐ Yes	□ No
Unintentional weight loss	☐ Yes	□ No	Coughing up blood		□ No	Depression	☐ Yes	□ No
lb overmonth	ns		Chronic Cough	☐ Yes	□ No	Feeling suicidal	☐ Yes	□ No
			Shortness of Breath	☐ Yes	□ No	Other Psychiatric Issues or Trea	tment?	
Eyes, Ears, Nose, Mouth, Thr	<u>oat</u>							
Double vision	☐ Yes	□ No	Muscles/Joints/Skin					
Sinus congestion	☐ Yes	□ No	Skin disease / type		□ No	<u>Gastrointestinal</u>		
Bloody nose	☐ Yes	□ No	Muscle weakness	☐ Yes	□ No	Diarrhea	☐ Yes	□ No
Hearing loss	☐ Yes	□ No	Joint Pain	☐ Yes	□ No	Nausea / vomiting	☐ Yes	□ No
Dry throat / mouth	☐ Yes	□ No				Abdominal pain	☐ Yes	□ No
Difficult / painful swallowing	☐ Yes	□ No	Endocrine/Hormones			Reflux / heartburn	☐ Yes	□ No
Hoarseness	☐ Yes	□ No	Parathyroid disease	☐ Yes	□ No	Constipation	☐ Yes	□ No
Do you have a feeding tube?	☐ Yes	□ No	Thyroid disease	☐ Yes	□ No			
			Diabetes	☐ Yes	□ No	<u>Hematologic</u>		
<u>Genitourinary</u>						Bleeding problems	☐ Yes	□ No
Kidney stone	☐ Yes	□ No	Problems with Anesthesi	i <u>a</u> □ Yes	□ No	Anemia	☐ Yes	□ No
Human papillomavirus (HPV)	☐ Yes	□ No				Clotting disorders	☐ Yes	□No
FAMILY HISTORY (Parents G	Grandnaren:	s Sihlinas	Children: Livina or Decease	d) Please no	te for the	e following medical conditions:		
□ Diabetes	. аларалет	Stroke		Problems wit			id disease	
☐ High blood pressu	ire	☐ Lung		mmune diso		☐ Bleeding / Clotting of		
☐ Heart disease / at				Cancers: Who		— · · · · · · · · · · · · · · · · · · ·		
Other:					,,,,pe			
								
Patient/Legal Guardian/Surroga	ite Decision	Maker Signa	ature	Date		Relationship to Patient		
·								
Patient/Legal Guardian/Surroga	te Decision	Maker Print	ed Name					
*****	*****	*****	*****	******	*****	****	*****	****
FOR CLINIC USE ONLY: To		Yes!	No Dentures?Fu	IIPartia	ılN	lone MRSA (+) VRE (
Weightlbkg I	BP/_	P	ulsebpm Temp_	C/	F pain	(1-10) Heightc	m / in	
1				1.				
I	Patient	Label		1	PE	RMANENT PART OF MED	ICAL RE	CORD
NAME.			DOD.	1				
NAME:			DOB:	1			_	

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