METHODIST

Room #_____

HEAD AND NECK MEDICAL 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

_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____

Have you had any of the following cancers? (check all that apply):
☐ Head and neck cancer ☐ Thyroid cancer ☐ Skin cancer ☐ Leukemia/lymphoma ☐ Other cancers:_____
What year(s) were you diagnosed? _____
Have you had any of the following treatments for cancer? (check all that apply):
☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Other:_____
Treatment facility name(s):_____ Locations (city, state)_____
Treating physicians first and last names: _____

MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS
Including: prescription, over the counter, birth control, vitamins, etc.

MEDICATION NAME	DOSE / FREQUENCY

ALLERGIES

PLEASE LIST ALL MEDICATION / FOOD ALLERGIES
DO YOU HAVE A LATEX ALLERGY? Yes☐ No☐

MEDICATION / FOOD ALLERGY	REACTION

PHARMACY: _____ CITY, STATE:_____ PHONE#:_____

Please complete back of form

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

METHODIST

SOCIAL HISTORY: This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Employment status: ☐ Full-time ☐ Part-time ☐ Retired ☐ On disability ☐ Stay at home ☐ Looking for work
What type of work do you do / have you done? _____

Tobacco Use: ☐ Current ☐ Never ☐ Former (Year You Quit_____) What type(s)? ☐ cigarettes ☐ cigars ☐ vape ☐ chew
How much do/did you use per day (average)?_____/ How many years? _____

Do you drink alcohol currently? ☐ Yes ☐ No How many drinks per week *(1 drink = 12oz beer, 5oz wine, 1.5oz liquor)*?_____
Have you ever had a drinking problem? ☐ Yes ☐ No When did you quit (if no longer using)?_____

Recreational drugs: ☐ Current ☐ Never ☐ Former (Year You Quit_____) Type of drugs? _____

Do you have a "pain contract" with a physician? ☐ Yes ☐ No Do you have objections to blood transfusions? ☐ Yes ☐ No
Do you make health care decisions for yourself? ☐ Yes ☐ No Do you have an advanced directive/living will? ☐ Yes ☐ No
Do you need help with daily activities *(bathing, eating, walking, getting dressed, etc.)*? ☐ No ☐ Sometimes ☐ Often
What is your mobility? ☐ Walk without help ☐ Walk with a cane/walker ☐ Mostly wheelchair ☐ Unable to walk at all

Living conditions: ☐ House/Apartment by myself ☐ House/Apartment with others ☐ Homeless ☐ Facility
Facility name:_____ Facility phone#:_____

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Have you had any of these problems in the last several weeks?

Constitutional/Whole Body

Night sweats	☐ Yes	☐ No
Recurrent fevers	☐ Yes	☐ No
Unintentional weight loss	☐ Yes	☐ No
_____lb over _____months		

Eyes, Ears, Nose, Mouth, Throat

Double vision	☐ Yes	☐ No
Sinus congestion	☐ Yes	☐ No
Bloody nose	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Dry throat / mouth	☐ Yes	☐ No
Difficult / painful swallowing	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Do you have a feeding tube?	☐ Yes	☐ No

Genitourinary

Kidney stone	☐ Yes	☐ No
Human papillomavirus (HPV)	☐ Yes	☐ No

Heart and Lung

Chest Pain / angina	☐ Yes	☐ No
Vascular / artery disease	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Muscles/Joints/Skin

Skin disease / type_____	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No

Endocrine/Hormones

Parathyroid disease	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Problems with Anesthesia ☐ Yes ☐ No

Neurologic/Psychiatric

Frequent Headaches	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Feeling suicidal	☐ Yes	☐ No
Other Psychiatric Issues or Treatment?		

Gastrointestinal

Diarrhea	☐ Yes	☐ No
Nausea / vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Reflux / heartburn	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Hematologic

Bleeding problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Clotting disorders	☐ Yes	☐ No

FAMILY HISTORY *(Parents, Grandparents, Siblings, Children; Living or Deceased)* Please note for the following medical conditions:

☐ Diabetes ☐ Stroke ☐ Problems with anesthesia ☐ Thyroid / Parathyroid disease
☐ High blood pressure ☐ Lung disease ☐ Immune disorders ☐ Bleeding / Clotting disorders
☐ Heart disease / attacks ☐ Kidney disease ☐ Cancers: Who/Type:_____

Other: _____

_____ _____ _____
Patient/Legal Guardian/Surrogate Decision Maker Signature | Date | Relationship to Patient

_____
Patient/Legal Guardian/Surrogate Decision Maker Printed Name

****

FOR CLINIC USE ONLY: Teeth? ____Yes ____No___ Dentures? _____Full ____Partial _____None MRSA (+)_____ VRE (+)_____
Weight_____lb_____kg BP_____/_____ Pulse_____bpm Temp_____C / F pain (1-10)_____ Height_____cm / in

_____

_____

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD