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
End stage renal disease ☐ Yes ☐ No

Heart and Lung
ICD in place/home bipap/ congestive heart failure ☐ Yes ☐ No
Chest Pain / angina ☐ Yes ☐ No
Vascular / artery disease ☐ Yes ☐ No
Coughing up blood ☐ Yes ☐ No
Chronic Cough ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Home oxygen /+ severe pulmonary disease ☐ 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
If yes HgbA1C = or > 9 in last year ☐ 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
If yes Hgb < 8 within last 6 months ☐ 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 ☐ Venezuelan ancestry
☐ High blood pressure ☐ Lung disease ☐ Immune disorders ☐ Bleeding / Clotting disorders ☐ Other_____
☐ Heart disease / attacks ☐ Kidney disease ☐ Malignant hyperthermia ☐ Cancers: Who/Type:_____

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

_____
Patient/Legal Guardian/Surrogate Decision Maker Printed Name

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

_____
_____
_____

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD