UT★Physicians

UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

New Patient Questionnaire
Otorhinolaryngology-Head & Neck Surgery

Name	MRN	DOB	Date

Telephone		
H	W	M

Pharmacy	
Name	Telephone

How did you hear about us?
- ☐ Sent by another physician (If so, please give name below.)
- ☐ Sent by a friend
- ☐ Internet search
- ☐ UT reputation
- ☐ Other *(Specify)*

Physician #1 (☐ sent by this physician)		
Name	Fax	Telephone
Address	City, State	Zip

Physician #2 (☐ sent by this physician)		
Name	Fax	Telephone
Address	City, State	Zip

Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

START HERE:

What symptom gives you the most trouble?

Next page→

Review of Systems

The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.

	Yes	No	Treated by another physician
General			
Nausea	O	O	O
Weight gain	O	O	O
Weight loss	O	O	O
Fevers/chills	O	O	O
Ears, Nose & Throat			
Hoarseness	O	O	O
Hearing loss	O	O	O
Draining ear	O	O	O
Vertigo	O	O	O
Loud snoring	O	O	O
Daytime sleepiness	O	O	O
Mouth sores	O	O	O
Tooth problems	O	O	O
Painful/difficult swallowing	O	O	O
Ringing in the ears	O	O	O
Eyes			
Double vision	O	O	O
Blurry vision	O	O	O
Cardiac			
Chest pain	O	O	O
Short of breath	O	O	O
Respiratory			
Wheezing	O	O	O
Cough	O	O	O

	Yes	No	Treated by another physician
Gastro-intestinal			
Heartburn	O	O	O
Belly pain	O	O	O
Diarrhea	O	O	O
Constipation	O	O	O
Vomiting	O	O	O
Skin			
Rashes	O	O	O
Ulcers	O	O	O
Musculo-skeletal			
Muscle pain	O	O	O
Muscle weakness	O	O	O
Endocrine			
Cold intolerance	O	O	O
Heat intolerance	O	O	O
Excessive thirst	O	O	O
Hematologic			
Anemia	O	O	O
Bleeding	O	O	O
Bruising	O	O	O
Neurological			
Seizures	O	O	O
Psychiatric			
Depression	O	O	O
Anxiety	O	O	O

Next page→

Past History

Do you have any of the following medical problems?

- O Arthritis
- O Asthma
- O Bleeding disorder
- O Cataracts
- O Chronic fatigue syndrome
- O Depression
- O Diabetes
- O Fibromyalgia
- O Gastritis
- O Glaucoma
- O Hepatitis
- O High blood pressure
- O Heart disease
- O Immunodeficiency
- O Kidney disease
- O Meningitis
- O Migraine headache
- O Mitral valve prolapse
- O Peptic ulcer disease
- O Seizures
- O Thyroid disease
- O Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

O Yes
O No
(If yes, please give details.)

Please list your current medications.

Are you allergic to any medications?

O Yes
O No
(If yes, please give details.)

Family History

Do any of your family members have any of the following conditions?

- O Allergy
- O Asthma
- O Bleeding disorder
- O Cancer
- O Cystic fibrosis
- O Heart disease
- O Immunodeficiency

Social History

What is your occupation?

Have you had any recent change in your home or work environment? O Yes O No	Details
Do you smoke? O Yes O No	Details
Do you drink alcoholic beverages? O Yes O No	Details
Have you ever used cocaine or other illicit substances? O Yes O No.	Details