ENT Family Clinic ~ Sinus and Snoring MD
Medical History Questionnaire

Patient Name: _____ Gender: _____ Age: _____ Date: _____

Reason for visit: _____

Please check all that apply below:

_____ Chest Pain	_____ Nasal Allergies	_____ Asthma	_____ Dizziness
_____ Difficulty Breathing	_____ Sinus Infections	_____ Diabetes	_____ Hearing Loss
_____ Heart Issues	_____ High Blood Pressure	_____ Postnasal Drip	_____ Stroke
_____ Lung Issues	_____ Hepatitis	_____ Nose Bleeds	_____ TIA's
_____ Kidney Issues	_____ Ulcer	_____ Stuffy Nose	_____ Heart Murmur
_____ Positive HIV/AIDS	_____ Anemia	_____ Headaches	_____ Snoring Sleep Apnea

Please check Below:	**Yes**	**No**		**Yes**	**No**
Recent Cold / Flu	☐	☐	Acid Reflux / GERD	☐	☐
Chest Pain / Angina	☐	☐	Stroke / TIA / Seizures	☐	☐
Heart Attack / Irregular Heartbeat	☐	☐	Paralysis / Muscle Disease	☐	☐
Angioplasty / Stent	☐	☐	Bleeding Problems / Easy Bruising	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Asthma / COPD / Shortness of Breath	☐	☐	Thyroid Disease	☐	☐
Sleep Apnea / CPAP / Sever Snoring	☐	☐	Smoking	☐	☐
Alcohol Use	☐	☐	Recreational Drugs	☐	☐
Substance Dependency	☐	☐	Unusual Reaction to Anesthesia	☐	☐
Possibility of Pregnancy	☐	☐	Exposure to HIV / AIDS	☐	☐
Liver / Kidney Disease	☐	☐			

Family Medial History: _____

Please list all operation and hospitalizations you have ever had, along with approximate dates:

_____

_____

Major Illness not listed above: _____

Primary Care Physician: _____ Phone Number: _____

List Current Medications (prescription and nonprescription) and supplements: None ☐

1.	2.	3.
4.	5.	6.
7.	8.	9.

List all Known Allergies: None ☐

1.	2.	3.
4.	5.	6.

I agree that all the information above is complete and correct.

Patient or Guardian Signature: _____ Date: _____