Name:_____ Date of Birth: _____ Today's Date: _____

MONROE EAR, NOSE AND THROAT
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record

List any medical problems that other doctors have diagnosed	Have you had any of the following recently
☐ High Blood Pressure ☐ Atrial Fibrillation ☐ Mitral Valve Prolapse ☐ Pace Maker ☐ Heart Attack date_____ ☐ Allergy ☐ Thyroid problems _____ ☐ Asthma ☐ Seizure ☐ Cancer Type & year _____ ☐ Diabetes ☐ Sleep Apnea ☐ Gastroesophageal reflux ☐ Bleeding disorders	☐ Anxiety ☐ Recent Illness ☐ Fatigue ☐ Hearing loss ☐ Ear pain ☐ Cough ☐ Abdominal pain ☐ Trouble swallowing ☐ Heartburn ☐ Muscle weakness ☐ Rash

Surgeries

Year	Surgery	Surgeon

Allergies to medications

Medication	Reaction you had

Enviromental Allergies including Latex or food

Name:_____ Date of Birth: _____ Today's Date: _____

List your prescribed drugs and over-the-counter drugs, vitamins, herbals and inhalers		
Name of the Drug	Strength	Frequency Taken

Family History	
Father	☐Head and Neck Cancer ☐Skin Cancer ☐Thyroid Disease ☐Sleep Apnea ☐Chronic Ear Disease ☐Childhood Hearing loss
Mother	☐Head and Neck Cancer ☐Skin Cancer ☐Thyroid Disease ☐Sleep Apnea ☐Chronic Ear Disease ☐Childhood Hearing loss

HEALTH HABITS				
Pain Management Program	Physician:			
Alcohol	Do you drink alcohol? ☐ No	☐ Yes	☐ Former	
	☐ Rarely	☐ 1-4/week	☐ 7-14/week	☐ More than 14/week
Tobacco	Do you use tobacco? ☐ No	☐ Yes	☐ Former	
	☐ 10/day (half pack)	☐ 20/day (pack)	☐ 30/day (1 1/2 pack)	☐ 40/day (2 packs)
	☐ # of years	☐ Or year quit		
	☐ Smokeless/Chewing Tabacco			