

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Otolaryngology Health History Questionnaire	NAME: _____ REG #: _____ BIRTHDATE: _____
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***Please fill out the NAME, REG #, and BIRTHDATE fields in both pages.**

***Please sign bottom of page 2.**

Today's Date: _____ (mm/dd/yy) **Appointment Date:** _____

How did you hear about this office? _____

Were you referred to us by another physician? No Yes If yes, please write:

Physician's Name: _____

Physician's Address: _____

May we send a letter to the referring physician about your evaluation and treatment? Yes No

REASON FOR VISIT (Problem/Condition): _____

MEDICAL HISTORY

What is your height? _____ What is your weight? _____

Do you have any of the following?

Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes or low blood sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease or yellowing of skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of radiation to the face	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of other cancer(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			History of immune disorder(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergies: No Yes. If yes, please list (if you need more space, use "Additional Information" field in page 2):

Please list any previous surgeries (if you need more space, use "Additional Information" field in page 2):

Year of Surgery	Type of Surgery	Reason for Surgery	Problems or Complications

Please list any other health problems (if you need more space, use "Additional Information" field in page 2):

Please list all medications you are currently taking (including over the counter and herbal medications)

**if you need more space, use "Additional Information" field in page 2*

Name of medication	Dose	Reason for taking medication

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REVIEW OF SYSTEMS

Do you presently have any of these problems? Please check Yes or No

	Yes	No		Yes	No
Chest pain or irregular heartbeats?			High blood pressure, fast or slow heart rate?		
Convulsions, seizures or memory loss?			Hearing loss, nosebleeds, lumps in neck?		
Failing vision or double vision?			Heat intolerance or weight loss or weight gain?		
Female: Currently pregnant?			Stomach pain, nausea, vomiting, diarrhea or bleeding?		
Skin rash or ulcers?			Frequent cough or shortness of breath?		
Burning, bleeding, pain or other problems when passing urine?					

SOCIAL HISTORY

Are you married? No Yes
 Do you smoke? No Yes (If yes, _____ pack(s)/per day for _____ years)
 Have you quit within the past year? No Yes
 Do you drink alcohol? No Yes If yes, number of drinks per week _____
 Do you have a history of IV drug abuse or other HIV/AIDS risk factors? No Yes


FAMILY HISTORY: Do you have a family history of:

Heart disease (under the age of 45)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Life threatening reactions to anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clotting disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADDITIONAL INFORMATION:

 Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yy)

 Signature of Provider Provider Number Date)mm/dd/yy) _____ A.M./ P.M.
 Time

POD-0672	REV: 11/10 HIM: 11/10	Medical Record		Health History Questionnaire
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