



**Nevada Eye & Ear**  
**Ear, Nose & Throat Patient Questionnaire:**

**Date:** \_\_\_\_\_ **Name:** \_\_\_\_\_

Welcome to our clinic! Who referred you here? \_\_\_\_\_

Please describe in brief the symptom or set of symptoms that brought you here:

\_\_\_\_\_

Do you have any of the following symptoms or problems? (Circle any that apply to you.)

<u>EAR</u>	<u>MOUTH/THROAT</u>	<u>NECK/SKIN</u>	
pain	breathy voice	neck lump	
drainage	shortness of breath	thyroid lump	
bleeding	noisy breathing	neck pain	
itching	wheezing	pain in front of ear	
Q-tip use	non-healing lesion	pain when pressing neck	
hearing loss	pain	swelling	
ear ringing	swelling	tunnels/openings	
spinning/dizzy	bad breath	drainage	
imbalance	bad voice	bleeding	
nausea/dizzy	hard to talk	skin lesion	
past ear injury	hard to swallow	changing mole	
past ear surgery	nausea/vomiting	past throat/neck cancer	
<u>NOSE</u>	drink goes into nose	past throat/neck surgery	
blocked breathing	pain when swallowing	past skin cancer	
clear discharge	unable to open mouth wide	<u>GENERAL</u>	
sneezing	voice change	fever	high blood pressure
eyes itching/tearing	choking	chills	kidney problems
yellow/green	cough	weight loss	stroke
discharge	clearing throat	weight gain	immune problems
bleeding	heartburn	fatigue	blood disorder
swelling	bitter/sour taste	can't stand cold	hepatitis
decreased vision	past peptic ulcer	can't stand heat	HIV infection
double vision	past hiatal hernia	nervousness	Tuberculosis/TB
excessive tearing	snoring	anxiety	
bulging eyes	daytime sleepiness	feeling heart pound	
sunken eyes	drowsy when watching T.V.	chest pain	
numbness	drowsy when driving	breathless w/ exertion	
decreased smell	sleep apneas	breathless lying down	
absent smell	bed wetting	fainting	
deformity		psychiatric problems	
nose injury		thyroid problems	
past polyps		diabetes	
past nasal surgery		heart problems	

What medical problems that might require medication or hospitalization have you had or are you being treated for now? (List duration of illness and the doctor taking care of it.)

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What surgeries have you had? (Include dates)

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Do you have any allergies to medications? List the medication and reactions to each one: (rash, itching, hives, swelling, shortness of breath.)

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Please list the medications and doses, (if you remember) that you take at this time:

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Do you currently smoke?  YES  NO

When did you quit smoking, if you've smoked in the past? \_\_\_\_\_.

Up to how many packs a day do you, or did you smoke? \_\_\_\_\_ packs a day.

How many years have you smoked? \_\_\_\_\_ years.

How much alcohol do you drink? \_\_\_\_\_ per day/per week

Have you been a heavy drinker?  YES  NO

Have you ever abused drugs?  YES  NO Types: \_\_\_\_\_.

Are there members of your family such as parents, siblings, grandparents, etc. Who have major illness or ear/nose/throat problems? Please list the illness/problem:

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