CHAPEL HILL
EAR, NOSE & THROAT

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ADULT NEW PATIENT QUESTIONNAIRE

DATE: _____

PATIENTS NAME _____ CHART NUMBER: _____

REASON for Today's Visit: _____

Referring Physician: _____ Physician's Address/phone _____

_____

Approximate Weight: _____ Height: _____

MEDICAL HISTORY

Do you have or have you been treated for any of the following: (check all that apply)?

_____ Aids/HIV	_____ Bleeding disorder	_____ Arthirities	_____ Meningitis
_____ Asthma	_____ Heart disease/heart attack	_____ Depression	_____ Thyroid
_____ Tuberculosis (TB)	_____ Kidney disease	_____ Sickle cell anemia	
_____ Diabetes	_____ Mitral valve prolapses	_____ Liver disease	
_____ Seizures	_____ Glaucoma	_____ Cataracts	
_____ Stroke	_____ High blood pressure	_____ Ear disease	
_____ Cancer (type: _____)	_____ Transplant (type: _____)	_____ Sleep apnea	

Other: _____

HOSPITALIZATION(S) AND/OR SURGERY(S):

Date	Reason	Hospital

Professional Village | 109 Conner Drive, Suite 207 | Chapel Hill, NC 27514 | Phone: 919-967-5599 | Fax: 919-967-5698

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Patient Name: _____ Date: _____ Chart Number: _____

CURRANT MEDICATIONS: (including vitamins, herbs, and over-the-counter):

NAME	DOSE	NAME	DOSE

ALLERGIES TO MEDICATIONS?

YES _____ NO _____

List ANY medications you are allergic to and the reaction you had: _____

FAMILY HISTORY (Please check all that apply to your family members):

_____ Allergy _____ Asthma _____ High blood pressure _____ Cystic fibrosis

_____ Stroke _____ Bleeding disorder _____ Sinus disease _____ Heart disease

_____ Cancer (type: _____) OTHER: _____

SOCIAL HISTORY & HEALTH BEHAVIORS

Have you ever smoked cigarettes, cigars, and pipes _____ YES _____ NO?

If you have stopped smoking, when did you quit: _____ How long did you smoke: _____

If you still smoke, how much do you smoke per day? _____ Packs

How much alcohol do you drink per week: _____

Have you ever used any addictive substances or drugs _____ YES _____ NO?