Alamo ENT Associates
New Patient Questionnaire
MRN: _____

PLEASE FILL OUT QUESTIONNAIRE COMPLETELY: IF DOES NOT PERTAIN PLEASE PUT "N/A"

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

What is the reason for your visit today? When did your symptoms start?

_____

How did you find out about us? Were you referred by a Physician? (Yes or No) If so, who?

_____

Do you have a Primary Care Physician (PCP)? If so, please list the name and location.

_____

Preferred Pharmacy Name: _____

_____

Address or Cross Streets: Zip code Phone number

Please list any medical issues you have ever been treated for, including ENT issues like allergies.

_____

Is there anything else you take medicines for?

_____

Please list any surgeries or procedures (including tonsillectomy and ear tubes) you have ever had and when they were performed.

Surgery Year

_____

_____

_____

_____

_____

Please list any prescription or over the counter medications, herbs, or supplements that you take.

Medication Dose How often taken Last taken

_____

_____

_____

_____

_____

_____

_____

_____

Please list any medication allergies and your reactions to them.

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Please describe any smoking or smokeless tobacco use at any time in your life. Please include vaping. If you have never used tobacco, please write "Never."

Type of Tobacco | How much per day (ex, number of packs) | Year begun | Year quit

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Please describe any alcohol use at any time in your life.

Type of Alcohol | How much per day (ex, number of beers, glasses of wine) | Year begun | Year quit

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Please describe any drug use at any time in your life.

Type of Drugs | How often (ex, how many times per week) | Year begun | Year quit

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Please list any medical problems that any family members have had and indicate who had them.

Please comment on at least one first degree relative (mom, dad, siblings, children). Do not include non-blood relatives including spouses. **Example:** Hypertension, Cancer, Diabetes, etc.

Please circle any of the following things that are bothering you: If none apply, circle NONE

- **ENT:** Dizziness, dry mouth, dysequilibrium, problems swallowing, hoarseness or voice changes, itchy ears, feeling like something is stuck in your throat, hearing loss, coughing up blood, loss of smell, mouth ulcers, nasal obstruction, neck mass, pain with swallowing, nosebleed, ear pain, draining ear, post nasal drip, runny nose, throat clearing, throat pain, ringing or buzzing sound in ear, vertigo
- **Musculoskeletal:** Neck pain, neck stiffness, musculoskeletal pain
- **Allergic/Immunologic:** Immunodeficiency, increased infections, itchy eyes, itchy throat, sneezing
- **Cardiovascular:** Irregular heartbeat, chest pain, history of heart attack, increased heart rate
- **Constitutional:** Daytime sleepiness, Stop breathing during sleep, fatigue, fever, night sweats, weight gain, weight loss
- **Endocrine:** Cold intolerance, hair loss, heat intolerance
- **Eyes:** Blurry vision, double vision, eye bulging, vision loss
- **Gastrointestinal:** Cirrhosis, constipation, diarrhea, heartburn or reflux, vomiting blood, hepatitis, blood in stools, nausea, vomiting
- **Genitourinary:** Pain with urination, blood in urine, incomplete urinary emptying, incontinence, increased urinary frequency
- **Hematologic/Lymphatic:** Bruising, blood clots, heavy periods, increased bleeding
- **Skin:** Rash, skin itching
- **Neurological:** Confusion, decreased sensation, headache, memory loss, seizures, stroke, weakness
- **Psychological:** Anxiety, depression, loss of motivation
- **Respiratory:** Wheezing, cough, shortness of breath

Have you ever had any allergy testing? When?

What were you allergic to?

Have you ever taken allergy shots? Yes No Year begun _____ Year ended_____
Were these helpful? Yes No

Have you or any family members had any problems with general anesthesia? Yes No
If yes, please describe what type of problems and to whom they occurred.
