Head & Neck Surgical Group
425 West 59th St., 10th Fl.
New York, NY 10019

# PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ HEIGHT: _____WEIGHT:_____

## REVIEW OF SYSTEMS – CHECK ALL THAT APPLY:

***Head & Neck***
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Discharge
___ Altered sense of smell
___ Sinusitis
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Lumps in the neck
___ Allergies

***Respiratory System***
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ Lung cancer

***Neurologic***
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient black-outs
___ Transient vision loss
___ Seizures
___ Strokes

***General***
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easy Bruisability
___ HIV infection or AIDS
___ Psychiatric Diseases

**Gastrointestinal**
___ Difficult swallowing
___ Pain on swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver Disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers

***Cardiovascular***
__ Hypertension
__ Heart disease
__ Angina
__ Swelling oftheankles
__ Heart surgery
__ Angioplasty
__ Pacemaker
__ Anemia

***Endocrine***
__ Diabetes
__ Heat/cold intolerance
__ Thyroid imbalance
__ Menstrual disorders

***Urologic***
__ Difficulty on urination
__ Frequent urination
__ Blood in the urine
__ Prostate problems

***Other***
_____

| **Past and present medical problems:** | **Previous surgeries and dates (month/year)** | **List all current medications and dosages (including OTC):** |
|---|---|---|
| _____ | _____ ( / ) | _____ |
| _____ | _____ ( / ) | _____ |
| _____ | _____ ( / ) | _____ |
| _____ | _____ ( / ) | _____ |
| _____ | _____ ( / ) | _____ |
| _____ | _____ ( / ) | _____ |

**Do you smoke?**
___Yes ___ No
If yes, how much?

_____

**Do you drink alcohol?**
___ Yes ___ No
If yes, how much?

_____

**Any other information for Dr. ?**

_____

_____

_____

**Please list all allergies:**
(medications, inhalants, foods, contact allergies) _____

**Reason for today's visit:**_____

Patient Signature _____ Date _____

Physician Signature _____ Data _____