Date:____________________________________

CHIEF COMPLAINT/HISTORY OF ILLNESS:
What is the reason for today’s visit?____________________________________________________________________

How long have you had this problem?________________________________________________________________

How severe is this problem?   (Circle)  1  2  3  4  5  6  7  8  9  10
mild     2     3     4     5     6     7     8     9     10
very severe

How often does this problem occur?  [ ] constant  [ ] comes and goes

What makes it better?_______________________________________________________________________________

What makes it worse?_______________________________________________________________________________

What other symptoms are you having?________________________________________________________________

PAST MEDICAL HISTORY (Please check any illnesses you have):
[ ] High blood pressure  [ ] Asthma/Emphysema  [ ] Rheumatic fever  Others:____________________
[ ] Kidney disease  [ ] Stroke, mini-stroke  [ ] Sinusitis
[ ] Diabetes  [ ] Heart disease/Angina  [ ] Peptic ulcers
[ ] Neck/Back disease  [ ] Hepatitis/Liver disease  [ ] Thyroid disease
[ ] Poor circulation  [ ] Seizures  [ ] Bleeding problems
[ ] Cancer (please list type and date diagnosed):_____________________________________

PAST SURGICAL HISTORY (Please check any surgeries you have had):
[ ] Heart bypass/valve  [ ] Gall bladder  [ ] Prostate removal  Others:____________________
[ ] Coronary angioplasty  [ ] Lung surgery  [ ] Colon removal
[ ] Carotid artery surgery  [ ] Joint replacement  [ ] Appendix removal
[ ] Vascular bypass  [ ] Back surgery  [ ] Sinus surgery
[ ] Mastectomy  [ ] Brain surgery  [ ] Tonsillectomy
[ ] Heart transplant  [ ] Liver transplant  [ ] Kidney transplant
[ ] Ear surgery  [ ] Septoplasty  [ ] Neck surgery
[ ] Cancer surgery (please list type and date):_____________________________________

MEDICATIONS (List all your current medications and the dose you take):
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Do you take Aspirin or Ibuprofen?  [ ] Yes  [ ] No  Do you take Warfarin (Coumadin)?  [ ] Yes  [ ] No
Do you take any herbal medicines?  [ ] Yes  [ ] No  Have you taken steroids in the last year?  [ ] Yes  [ ] No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):
__________________________________________________________________________________________
__________________________________________________________________________________________

FAMILY HISTORY (Check all illnesses that run in your family):
[ ] Hearing loss  [ ] Alcoholism  [ ] Heart disease  Others:____________________
[ ] High blood pressure  [ ] Psychiatric illness  [ ] Cancer
[ ] Sickle cell anemia  [ ] Bleeding problems  [ ] Diabetes
[ ] Poor circulation  [ ] Anesthesia reaction  [ ] Stroke
[ ] Thyroid disease/cancer  [ ] Voice problems  [ ] Epilepsy
JOHNS HOPKINS OUTPATIENT CENTER
DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

PATIENT QUESTIONNAIRE - PAGE 2 OF 2

SOCIAL HISTORY:
Occupation_______________________________________ Marital status: [] Single  [] Married  [] Divorced
How many children do you have?____________________
Have you ever used tobacco?  [] Cigarettes  [] Cigar  [] Pipe  [] Chew  [] Never used tobacco
How much, and for how long have you used tobacco?________________________ per day for ______________ years
How much alcohol do you drink each day?______________________________________________________________
How much caffeine do you drink per day?_______________________________________________________________
List any street drugs you currently or have ever used:_____

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL:
[ ] Weight loss _________ pounds in the past _________ weeks  [ ] Fever, chills  [ ] Weakness or fatigue

EYES:
[ ] Double vision  [ ] Hearing loss  [ ] Nose bleeds  [ ] Swallowing pain
[ ] Loss of vision  [ ] Ringing in ears  [ ] Nose drainage  [ ] Voice change
[ ] Eye pain  [ ] Dizziness  [ ] Nasal congestion  [ ] Snoring
[ ] Eye drainage  [ ] Ear pain  [ ] Facial pain  [ ] Hoarseness
[ ] Dry eyes  [ ] Ear drainage  [ ] Headaches  [ ] Poor sleep
[ ] Tooth aches

CARDIOVASCULAR/PULMONARY:
[ ] Chest pain  [ ] Heart attack  [ ] Irregular heartbeat  [ ] Bronchitis
[ ] Poor circulation  [ ] Leg pain during walking  [ ] Frequent cough  [ ] Coughing up blood
[ ] Shortness of breath  [ ] Asthma or wheezing

GASTROINTESTINAL:
[ ] Stomach ulcers  [ ] Nausea/vomiting  [ ] Diarrhea  [ ] Frequent antacid use
[ ] Heartburn  [ ] Trouble swallowing  [ ] Abdominal pain  [ ] Blood in stool

GENITOURINARY:
[ ] Blood in urine  [ ] Pain during urination  [ ] Difficulty making urine

MUSCULOSKELETAL:
[ ] Neck or back pain  [ ] Muscle aches  [ ] Arthritis

NEUROLOGICAL:
[ ] Stroke  [ ] Ministroke or TIA  [ ] Head trauma  [ ] Seizure
[ ] Facial paralysis  [ ] Paralysis of arm or leg  [ ] Confusion  [ ] Memory loss
[ ] Numbness in face, arms or legs  [ ] Temporary loss of vision or speech control

SKIN:
[ ] Skin cancers  [ ] Allergy to tape, iodine or latex

PSYCHIATRIC:
[ ] Depression  [ ] Schizophrenia  [ ] Anxiety or panic attacks
[ ] Hallucinations  [ ] Other psychiatric disorder (please list):______________________________________

INFECTIONOUS DISEASE:
[ ] Hepatitis  [ ] HIV/AIDS  [ ] Mononucleosis  [ ] Shingles
[ ] Syphilis  [ ] TB  [ ] Any sexually transmitted disease______________________________

I have personally reviewed this history and review of systems:

Attending Physician Signature ___________________________ Date _____________
AUDIO-VISUAL CONSENT FORM

During your initial evaluation and any follow-up appointments, your doctor or a colleague may perform a transnasal fiberoptic examination (to visualize your voice box, throat or esophagus with a camera attached to a scope) or take photographs to document your progress. We ask your permission to use the photograph and/or videotape of you and/or your throat as deemed appropriate for research or educational purposes and in addition we may require the use of your medical data. Such material may identify you individually.

☐ I give permission ☐ I do not give permission for the Department of Otolaryngology- Head and Neck Surgery to use my audiovisual material and medical data.

TELEPHONE CONTACT CONSENT FORM

Often patients find reassurance in speaking with others that share the same disorder. We would like permission to add your name and telephone number to our list of patients who are willing to share information and personal experiences with other patients, particularly information about diagnostic and surgical procedures. Your name and telephone number will only be given specifically to patients with similar problems.

☐ I give permission ☐ I do not give permission for the Department of Otolaryngology- Head and Neck Surgery to offer my name and telephone number to other patients.

Patient’s signature _____________________________ Date ______________________________

Witness signature _____________________________ Date ______________________________