

House Clinic Health Questionnaire (Please complete)

Patient's Last Name

First Name

M.I.

Date

A. Reason For Visit:

B. Vitals: What is your height? _____ *feet* _____ *inches*. What is your weight? _____ *lbs*.

C. Medications:

List all the medications that you are taking. If you are attaching your own list, please check here

Name

Strength and Frequency

Name

Strength and Frequency

D. Allergies:

Do you have allergies to medications? No Yes Don't Know

If yes, please list below:

E. Review of Systems:

General:

Fatigue No Yes
Fever No Yes

Eyes:

Blurred Vision No Yes
Double Vision No Yes

Ears, Nose, and Throat:

Dizziness No Yes
Ear Drainage No Yes
Hearing Loss No Yes

Sinusitis No Yes
Allergies No Yes
Nasal Congestion No Yes
Runny Nose No Yes

Respiratory:

Short of Breath No Yes
Wheezing No Yes

Cardiovascular:

Chest Pain No Yes
Palpitations No Yes

Gastrointestinal:

Abdominal Pain No Yes
Heartburn No Yes

Genitourinary:

Blood in Urine No Yes
Painful Urination No Yes

Endocrine:

Cold Intolerance No Yes
Heat Intolerance No Yes

Neurological:

Fainting No Yes
Tremor No Yes
Weakness No Yes

Psychiatric:

Anxiety No Yes
Depression No Yes
Suicidal Thoughts No Yes

Blood/Lymphatic:

Easy Bleeding No Yes
Easy Bruising No Yes
Cancer No Yes

Infections:

HIV Positive No Yes
Syphilis No Yes
Tuberculosis No Yes
Hepatitis No Yes

Please Turn the Page and Finish the Questionnaire.....

F. Medical and Surgical History:

List all significant **medical conditions, surgeries, and hospitalizations**. Please include the relevant dates as well.

Medical Conditions / Surgeries / Hospitalizations	Date	Medical Conditions / Surgeries / Hospitalizations	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G. Family History:

Please check the box if any of the following diseases are common **in your family** or have occurred in any family member.

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Disorder | |

H. Social History:

1. Do you currently smoke cigarettes? No Yes _____ Packs per Day _____ Number of Years
2. Have you ever smoked in the past? No Yes _____ Packs per Day _____ Number of Years
3. Do you drink alcohol? No Yes _____ Glasses per Day / Week / Month
4. Do you drink caffeinated products? No Yes _____ Cups per Day
5. What is your present occupation? _____

I. Pharmacy:

Pharmacy Name: _____ Phone Number: _____
Address (Street, City): _____

J. Referring Physician and Primary Care Physician: (Fill out if you have been referred by your physician for this visit.)

Primary Physician's Name: _____	Referring Physician's Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

K. General Questions

Yes No

1. Have you ever had ear surgery?
2. Do you currently wear hearing aids?
3. Have you ever worn hearing aids in the past?
4. Do you have blood relatives with hearing loss? If yes, then whom? _____
5. Have you ever taken medications known to be damaging to your ears? If yes, circle the medication:
Gentamicin / Other Mycin Antibiotics / Vicodin / Viagra, Cialis / High Dose Aspirin / Others _____
6. Have you ever suffered a severe head injury?
7. Have you, in your job or hobbies, been exposed to loud noise levels?