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.

☐ Allergies ☐ Cancer ☐ Diabetes ☐ Migraines

☐ Asthma ☐ Heart Disease ☐ Hearing Loss ☐ Other _____

☐ Autoimmune Disease ☐ Stroke ☐ 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: _____

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?