



ENT Health History Questionnaire

Name _____ Date of Birth _____

Personal Health History	
Check if you have had any of the following	
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Obstructive Sleep Apnea
<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Sjorgen's Disease
<input type="checkbox"/> Esophageal Stricture	<input type="checkbox"/> Systemic Lupus Erythematosus
<input type="checkbox"/> Acoustic Neuroma	<input type="checkbox"/> Respiratory Papillomatosis
<input type="checkbox"/> Acute Otitis Media (Ear Infection)	<input type="checkbox"/> Sialadenitis
<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Sialolithiasis
<input type="checkbox"/> Branchial Cleft Cyst	<input type="checkbox"/> Singer's Nodes
<input type="checkbox"/> Cholesteatoma	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Stenosis of Trachea
<input type="checkbox"/> Disorder of Ear, Nose or Throat	<input type="checkbox"/> Subglottis Stenosis
<input type="checkbox"/> Enlargement of Tonsil or Adenoid	<input type="checkbox"/> Thyroglossal Duct Cyst
<input type="checkbox"/> Eustachian Tube Disorder	<input type="checkbox"/> Thyroid Nodule
<input type="checkbox"/> Fracture of Facial Bones	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Fracture of Nasal Bones	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Parathyroid Disorder	<input type="checkbox"/> Ulcer of Mouth
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Amyotrophic Lateral Sclerosis	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Cataract	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Loss of Sense of Smell	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Mastoiditis	<input type="checkbox"/> Vocal Cord Paralysis
<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Other
Previous Surgical Procedures	
Check if you have had any of the following	
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Nasal Septoplasty
<input type="checkbox"/> Nasal Fracture Repair	<input type="checkbox"/> Parathyroidectomy
<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Reduction of Nasal Turbinates
<input type="checkbox"/> Endoscopic Sinus Surgery	<input type="checkbox"/> Acoustic Neuroma Removal
<input type="checkbox"/> Cervical Lymph Node Removal	<input type="checkbox"/> Cataract Repair
<input type="checkbox"/> Esophagectomy	<input type="checkbox"/> Repair of Prominent or Protruding Ear
<input type="checkbox"/> Oral Cavity Lesion Removal	<input type="checkbox"/> Stapedectomy
<input type="checkbox"/> Submandibular Gland Removal	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Thyroglossal Cyst Removal	<input type="checkbox"/> Retinal Repair
<input type="checkbox"/> Blepharoplasty	<input type="checkbox"/> Laryngectomy
<input type="checkbox"/> Tracheotomy	<input type="checkbox"/> Tympanotomy
<input type="checkbox"/> Mastoidectomy	<input type="checkbox"/> Uvulopalatopharyngoplasty
<input type="checkbox"/> Modified Radical Neck Dissection	<input type="checkbox"/> Other
<input type="checkbox"/> Myringotomy With Tube Placement	<input type="checkbox"/> Other

Social History

Do you drive during the day? Yes No

Do you drive during the night? Yes No

Family History

Check all that apply

	Mother	Father	Brother	Sister
<input type="checkbox"/> Oitis Media (Ear Infection)				
<input type="checkbox"/> Sinusitis				
<input type="checkbox"/> Smoking				

Pediatric Health History

Check if you have had any of the following

<input type="checkbox"/> Cleft Lip	<input type="checkbox"/> Oitis Media (Ear Infection)
<input type="checkbox"/> Cleft Palate	<input type="checkbox"/> Other

Patient/Guardian Signature: _____ Date: _____